

Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: January-March 2021

Interim report
22 April 2021



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Key points

- **WHO is tracking disruptions to essential health services in the context of the COVID-19 pandemic** and has conducted two rounds of pulse surveys in 2020 and 2021 to assess the extent of these disruptions.

State of service disruptions

- **Overall, 94% of the 135 countries and territories** participating in the 2nd round of WHO's *National pulse survey on continuity of essential health services during the COVID-19 pandemic* reported some kind of disruption to services during the preceding three months from the date of survey submission (January-March 2021), only slightly down from the percentage of countries reporting service disruptions in the first pulse survey rounds during quarters 3 and 4 of 2020.
- **Primary care, rehabilitative, palliative and long-term care are most heavily affected**, with over 40% of countries reporting disruptions that affect the availability of and access to quality services, including for the most vulnerable individuals.
- **Potentially life-saving emergency, critical and operative care interventions continue to be disrupted in about 20% of countries**, likely resulting in substantial near-term impact on health outcomes. In addition, 66% of countries report disruptions in elective surgeries, with accumulating consequences as the pandemic continues.
- **Substantial disruptions span across all major health areas, including:** management of mental, neurological and substance use disorders (with particular disruptions to school based and other mental health programmes); noncommunicable diseases, including cancer, hypertension, diabetes, and chronic respiratory disease; neglected tropical diseases; infectious diseases, including tuberculosis (TB), human immunodeficiency virus (HIV), hepatitis and malaria; reproductive, maternal, newborn, child and adolescent health and nutrition; and immunization.
- **Nonetheless, the magnitude and extent of disruptions within countries decreased in 2021 compared to 2020**, with just over a third of a set of 35 tracer services in countries disrupted on average, as compared to half in quarters 2-3 of 2020. Immunization and rehabilitative and palliative care services saw the largest reduction among countries reporting disruptions.

Causes of service disruptions: supply and demand factors

- **To some extent, disruptions may be due to intentional strategic modifications to service delivery and access.** 40% of countries have limited access to one or more service delivery platforms, and nearly half of countries have scaled back at least one essential public health function or activity, including population-based services. In high-income countries, service disruptions are most often the result of strategic suspensions or modifications, as opposed to in low- and middle-income countries where disruptions are more frequently unplanned.
- **In 66% of countries, health workforce-related disruptions represent the most common causes of service disruptions.** Supply chain disruptions are also reported in 29% of countries.
- **On the demand side**, community fear and mistrust (57% of countries), patients not presenting (57% of countries), and financial difficulties caused by lockdowns (43% of countries) are the most commonly reported factors. Compared to 2020, fewer countries are reporting disruptions related to patients not presenting and community fear and mistrust.
- **In some countries, measures for COVID-19 control may be contributing to increased barriers to accessing care** (e.g. fear of getting infected, limited personal protective equipment or access, limitations in movement, loss of income, increased financial burden).

Country responses to minimize the consequences for essential health services

- **Most countries have implemented policies and plans on continuity of essential health services:** 87% have now defined the essential health services that must be maintained during the COVID-19 pandemic – about a 20% increase in 2021 compared to 2020.
- **Recommended strategies to restore or adapt service delivery are being implemented by many countries (66%).** The most frequently used approaches to restore or adapt service delivery include: communications, triaging to identify priority needs, recruitment of additional staff, redirecting patients to alternate care sites, provision of home-based care and, especially in high-income countries, use of telemedicine technologies.
- **Most countries are actively monitoring and tracking information to support essential health services continuity and implementation of mitigation strategies and approaches.** Two-thirds of countries have, additionally, designated a government unit or team dedicated to tracking and addressing the infodemic and health misinformation.

Conclusions

- **The key informant survey in 135 countries shows that health systems around the world are still being tested** more than one year into the pandemic. Nearly all responding countries reported at least one service disruption and disruptions were reported across all health areas, demonstrating the far-reaching impact of the pandemic on health systems.
- **Even moderate service interruptions can affect health outcomes,** and disruptions are especially concerning in settings where progress towards achieving universal health coverage (UHC) was already challenged, such as in fragile, conflict-affected and vulnerable settings. Ensuring continued availability of and access to high-quality services is of critical concern, particularly over the long-term as the indirect consequences of the pandemic are sustained.
- **The magnitude and extent of disruptions within countries has decreased since 2020,** and almost all countries have intensified efforts to respond to health systems challenges, bottlenecks and barriers to care brought on by the COVID-19 pandemic.
- **WHO will continue to support countries** to close the remaining gaps in service delivery, continue to respond to rapidly evolving priorities and needs throughout the course of the pandemic, and ensure that COVID-19 control strategies are in balance with other health priorities to secure continued access to comprehensive care for all.

Introduction

Countries worldwide are facing many challenges as they strive to ensure that health systems maintain essential health services as they respond to the COVID-19 pandemic. Disruptions to essential health services – including services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliation – are cause for serious concern and have the potential for severe adverse health effects, especially in vulnerable populations.

To better understand the extent of disruptions to essential health services caused by the COVID-19 pandemic worldwide, WHO has been tracking and monitoring the global situation. In 2021, WHO launched the second round of the *National pulse survey on continuity of essential health services during the COVID-19 pandemic*. This second survey follows up on WHO's 2020 pulse surveys: [Pulse survey on continuity of essential health services during the COVID-19 pandemic](#) (1); [Rapid assessment on the impact of the COVID-19 pandemic on noncommunicable disease resources and services](#) (2); [Rapid assessment on the impact of COVID-19 on mental, neurological and substance use services](#) (3); and [Round 1](#) (4); and [Round 2](#) (5) pulse surveys on immunization.

The second round, which integrates key questions from the 2020 WHO pulse surveys, was sent to key informants from 216 countries and territories. It aimed to support countries to rapidly assess the extent of impact of the COVID-19 pandemic on health systems and essential health services across the life course. The findings provide immediate insights from key informants into the current country experience, extent of disruptions to a set of tracer services against a rapidly changing context, the reasons for those disruptions and what mitigation strategies are in place.¹

By providing a rapid snapshot of the situation, the survey results can support decision-makers to systematically take stock of current challenges and inform policy dialogues and decision-making at national, regional and global levels to guide resources as the pandemic progresses. The findings can be used to support evidence-informed planning and implementation of mitigation strategies highlighted in WHO's [Maintaining essential health services: operational guidance for the COVID-19 context interim guidance](#) (6) and [Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic](#) (7).

The results are used for monitoring progress in WHO's 2021 COVID-19 strategic preparedness and response plan monitoring and evaluation framework for Pillar 9: Maintaining essential health services and systems and Pillar 2: Risk communication, community engagement (RCCE) and infodemic management for WHO's COVID-19 [Strategic preparedness and response plan \(SPRP\)](#) (8): Proportion of countries reporting disruption to essential health services during COVID-19 pandemic (disaggregated by type of service); Proportion of countries with capacities to track and address infodemic and health misinformation. It also contributed to monitoring for the [Global humanitarian response plan](#) (9).

¹ Countries provide a wide range of services for health protection, promotion, prevention, treatment and care, but it is possible to define a set of tracer indicators that provide a good picture of overall service coverage. See https://www.who.int/healthinfo/universal_health_coverage/UHC_WHS2016_TechnicalNote_May2016.pdf?ua=1.

Methods

Instrument

The pulse survey consisted primarily of multiple-choice and open-ended questions related to current national policies, plans and structures, disruptions to health services, reasons for disruptions, mitigation approaches, information tracking and priority needs. It included sections that target different key informants in the country, including a section on cross-cutting health system functions and services and focused sections on disruptions to service-specific areas.

In some cases, countries were also asked to upload or link to national plans and documents outlining the national package of essential health services and/or list of essential health services to be maintained during the pandemic, if available.

Survey sections and suggested key informants are included in the table below, and the full questionnaire is presented in Annex 1.

Table 1: Pulse survey sections and suggested key informants

#	Survey section	Suggested key informant(s)
1.	Health system functions and cross-cutting services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care	Health system, service delivery, or essential health services focal point(s)
2.	Reproductive, maternal, newborn, child and adolescent health and nutrition	Reproductive, maternal, newborn, child and adolescent health and nutrition focal point(s)
3.	Immunization	Immunization focal point(s)
4.	Human immunodeficiency virus and hepatitis	Human immunodeficiency virus and hepatitis focal point(s)
5.	Tuberculosis	Tuberculosis focal point(s)
6.	Malaria	Malaria focal point(s)
7.	Neglected tropical diseases	Neglected tropical diseases focal point(s)
8.	Noncommunicable diseases	Noncommunicable diseases focal point(s)
9.	Mental, neurological and substance use disorders	Mental health and psychosocial support focal point(s)

Across all survey sections, a total of 63 services were assessed. Across service delivery channels, the survey included services for primary care, emergency, critical and operative care; rehabilitative, palliative and long-term care; and auxiliary services. Across health service areas, the survey included services for reproductive, maternal, newborn, child and adolescent health (RMNCAH) and nutrition; immunization; communicable diseases; noncommunicable diseases (NCDs); neglected tropical diseases (NTDs); and mental, neurological and substance use (MNS) disorders. A list of these services is included in Annex 2.

Of note, questions related to specific service disruptions were modified from the first round to improve precision of results. In the first survey round(s), questions were asked about the disruption to up to 44 essential health services using a three-point ordinal scale:

- more than 50% of users not served as usual;
- 5-50% of users not served as usual; and
- less than 5% of users not served as usual.

In the second round, key informants were asked about the disruption of up to 63 essential health services using a four-point ordinal scale:

- more than 50% of users not served as usual;
- 26-50% of users not served as usual;
- 5-25% of users not served as usual; and
- less than 5% of users not served as usual.

In both survey rounds, respondents could also respond “Do not know” if information was not /not yet available on that service’s disruption, or “Not applicable” if the service/intervention is not usually delivered in the country.

Between the first survey (including the [Pulse survey on continuity of essential health services during the COVID-19 pandemic](#) (1); [Rapid assessment on the impact of the COVID-19 pandemic on noncommunicable disease resources and services](#) (2); and [Rapid assessment on the impact of COVID-19 on mental, neurological and substance use services](#) (3)) and second survey round, service disruptions were reported on a subset of 35 like tracer services, for which comparisons will be made.

Process for completion

Through collaboration between WHO headquarters and the Regional offices, WHO distributed the second round of the pulse survey through a secure web-based questionnaire in LimeSurvey software to WHO Country Offices in all six WHO Regions, together with instructions for completing the questionnaire. In cases where WHO has direct contact with national counterparts, the survey was distributed directly to ministry of health representatives. The questionnaire was made available in Arabic, English, Chinese, French, Portuguese, Russian and Spanish to support completion.

The survey was designed in modules so that focal points could complete their relevant sections simultaneously, which facilitated rapid completion, reduced the burden on individual respondents and ensured that each content area was assessed by the right technical focal point.

It was recommended that a survey focal point from WHO Country Office and/or within each ministry of health be designated to coordinate survey completion. This role included the following:

- identification of ministry of health focal points/key informants to complete each survey section;
- dissemination of the survey link to relevant ministry of health focal points/key informants; and
- tracking and following up completion of survey sections.

It was recommended that following submission of responses, the ministry of health organize a meeting with key informants, focal points and other key stakeholders to jointly review the results, discuss the implications of disruptions across the health system, flag critical challenges and bottlenecks and identify the most effective mitigation strategies and approaches for maintaining essential health services while responding to the COVID-19 pandemic. Where available, further data (such as from routine information systems) should be triangulated and contribute to the dialogue.

Data sharing agreement

Before completing any survey section, all key informants were asked to review the WHO data sharing agreement and contact WHO by email to notify any opt out. Findings from any countries, territories or areas opting out of the data sharing agreement are included only in global and regional aggregated findings. The data sharing agreement appears in Annex 1.

Responses

In total, 135 (63%) countries, territories and areas responded to the survey. Of those, 81 (41%) submitted all survey sections considered relevant to the context. A list of responding countries, territories and areas is included in Annex 3. Global and Regional response rates are included in Table 2.

The surveys were sent between December 2020 and February 2021. Survey responses were received primarily between January-March 2021, although a handful of responses were also received at the end of December 2020 and early April 2021. The reporting period of the survey refers to the 3-month period preceding the month of survey completion. For example, in the case of survey completion in January 2021, the responses reflect the situation in the country, territory or area during October, November and December 2020. Effectively, the majority of survey responses capture the magnitude of disruption of essential health services between October 2020-February 2021.

Most responses were submitted through the online portal. A few responses were received by email and were then entered into the online platform by the technical team at WHO headquarters.

Data from the questionnaire were downloaded directly from the web-based platform to a Microsoft Excel database for analysis. The analysis presented in this report is based on unweighted country and territory data.

In both survey rounds, 'Do not know' and 'Not applicable' responses were excluded from the denominators in analyses, unless considered pertinent.

Limitations

The limitations of the survey should be taken into account in the interpretation of findings. In general, responses provided by key informants reflect self-assessment, which may be prone to bias and lacks validation.

The type and mix of respondents and method of survey completion also varied across countries, territories and areas. Respondents included health policy advisors, directors of health services and health systems, directors of programmes, monitoring and evaluation focal points, public health officers, health systems and services officers and incident management team focal points. Coordination between ministry of health focal points prior to submission also varied; in some cases, key informants submitted survey responses individually, and in other cases survey section responses were reviewed and validated through a cross-cutting consultation prior to submission.

It is also critical to note that national-level data may not reflect subnational variability within countries in the interpretation of findings. Additionally, settings were at different stages of the COVID-19 pandemic when they submitted their responses, so variations in cross-country comparisons are to be expected. Moreover, the survey design resulted in submission of different combinations of survey sections by each country, territory and area. Consequently, each survey section has a different denominator, which must be considered in interpretation of aggregated results across countries and survey sections.

Different numbers and combinations of participating countries introduces potential bias into global comparisons between survey rounds. Moreover, countries/territories/areas that could not participate in the second round may include severely impacted countries/territories/areas that were not able to report, resulting in a potential underestimation of disruptions globally. Response rates also varied across regions, limiting the extent of regional comparisons.

Finally, the novelty of concepts and terminology related to essential health services, service continuity, service disruptions and mitigation strategies may have been interpreted differently by respondents, with potential implications on results.

Table 2: Overall and section-specific response rates

WHO region	Overall response rates		Survey section response rates								
	Complete survey submission (submission of all relevant sections) N (%)	Complete + partial survey submissions (submission of at least 1 section) N (%)	Section 1. Health system functions and cross-cutting services N (%)	Section 2. RMNCAH & nutrition N (%)	Section 3. Immunization N (%)	Section 4. HIV and hepatitis N (%)	Section 5. TB N (%)	Section 6. Malaria N (%)	Section 7. Neglected tropical diseases N (%)	Section 8. Non-communicable diseases N (%)	Section 9. Mental, neurological, and substance use disorders N (%)
African region	30 (65%)	40 (85%)	36 (77%)	38 (81%)	33 (70%)	35 (74%)	35 (74%)	32 (74%)	33 (75%)	38 (81%)	37 (79%)
Region of the Americas	16 (30%)	29 (54%)	25 (46%)	29 (54%)	23 (43%)	22 (41%)	23 (43%)	11 (65%)	11 (52%)	28 (50%)	27 (50%)
Eastern Mediterranean region	15 (68%)	21 (95%)	17 (77%)	19 (86%)	19 (86%)	17 (77%)	16 (73%)	8 (100%)	10 (83%)	19 (86%)	20 (91%)
European region	12 (23%)	23 (43%)	16 (30%)	18 (34%)	21 (40%)	19 (36%)	19 (36%)	1 (20%)	1 (25%)	18 (34%)	18 (34%)
South-East Asian region	8 (73%)	9 (82%)	9 (82%)	8 (73%)	9 (82%)	9 (82%)	8 (73%)	7 (78%)	6 (75%)	9 (82%)	8 (73%)
Western Pacific region	7 (24%)	13 (45%)	9 (31%)	9 (31%)	7 (24%)	10 (34%)	11 (38%)	8 (80%)	9 (60%)	9 (31%)	11 (38%)
Global	88 (41%)	135 (63%)	112 (52%)	121 (56%)	112 (52%)	112 (52%)	112 (52%)	67 (73%)	70 (67%)	121 (56%)	121 (56%)

Note: The survey was sent to 216 countries, territories, and areas. Response rates are calculated based on contexts where services are considered relevant. Malaria section is considered relevant in 92 contexts and NTDs section is considered relevant in 104 contexts.

Results

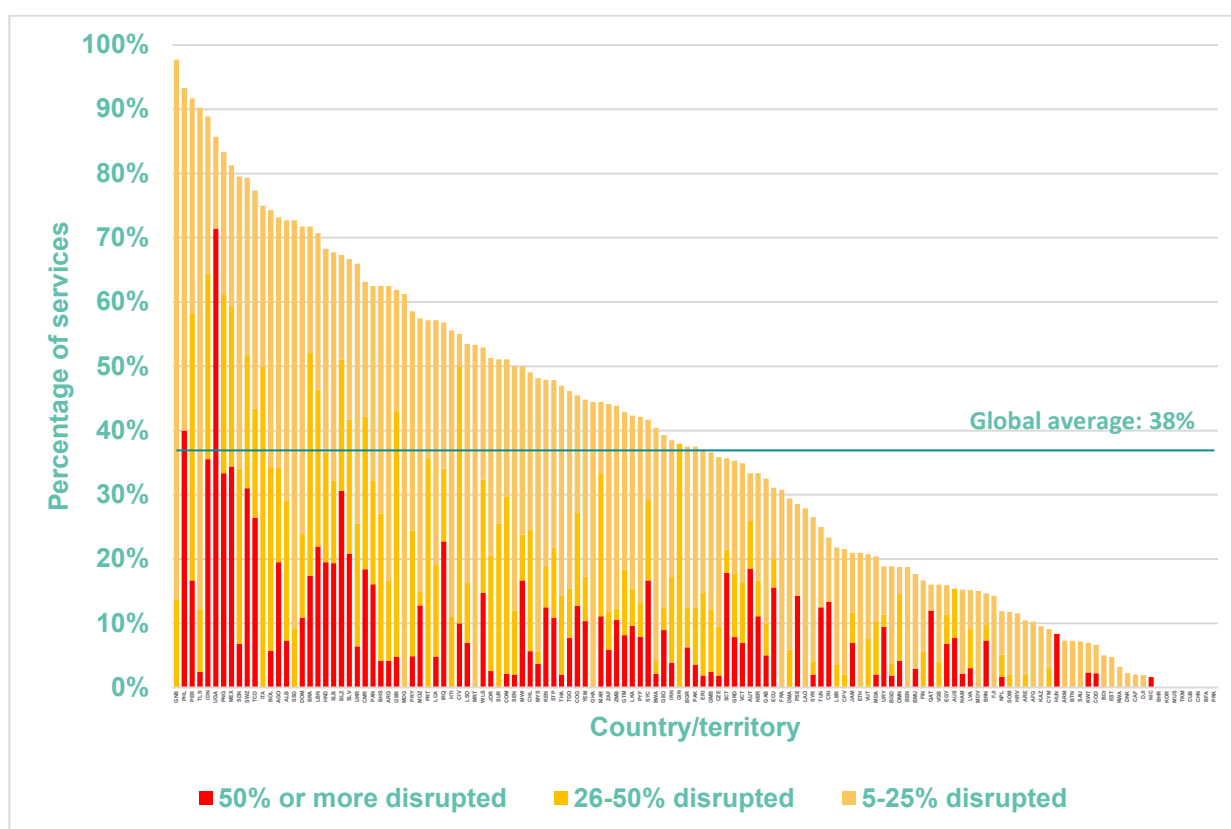
Overall service disruptions

The type and extent of services affected by the COVID-19 pandemic varied across countries and regions.

- 94% of participating countries reported disruptions in at least one essential health service.
- 34% of countries reported disruptions in over half of services (with approximately 9% of countries reporting disruptions in 75–100% of services and 25% reporting disruptions in 50–74% of countries).
- 29% of countries reported disruptions in 25–49% of services.
- 32% reported disruptions in less than 25% of services.
- Only 6% countries reported no service disruptions.

On average, disruptions were reported in over one-third of services (38% of services). See Figure 1, below.

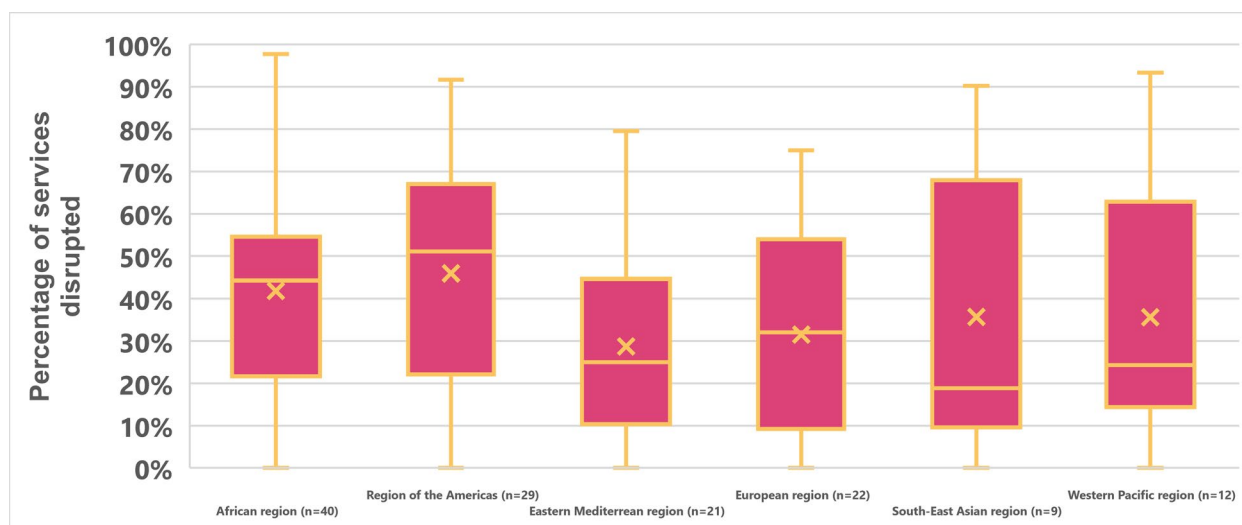
Figure 1: Percentage of services disrupted per country (number of tracer services = 63)



Denominator: represents responses from countries/territories/areas that responded to at least one survey section and consented to data sharing agreement. Percentages may not add up to exactly 100% due to rounding.

Some variation was seen in the percentage of services disrupted across regions and income groups (see Figures 2-3, below). Overall, countries in the WHO Region of the Americas reported the highest average percentage of services disrupted per Region, although these findings should be interpreted with caution, given the varied response rates across regions. Countries in high-income groups report fewer disruptions compared to countries in other income groupings. Overall, wide variation is seen in the level of disruption reported across countries within each region and income group.

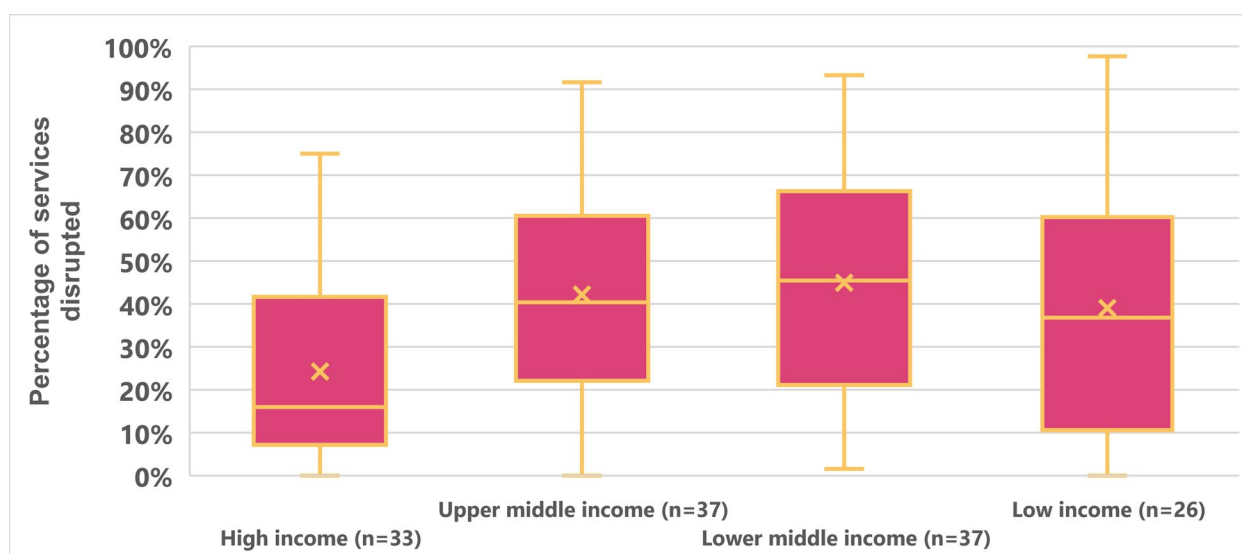
Figure 2: Percentage of services disrupted by region (n=133)



Denominator: represents responses from countries/territories/areas that responded to at least one survey section and reported on disruption levels for at least one service.

X indicates the average percentage of disrupted services per country/territory/area in each region; the line across the bar in the middle quartiles indicates the median percentage of disrupted services reported per country/territory/area in each region.

Figure 3: Percentage of services disrupted by income group (n=133)

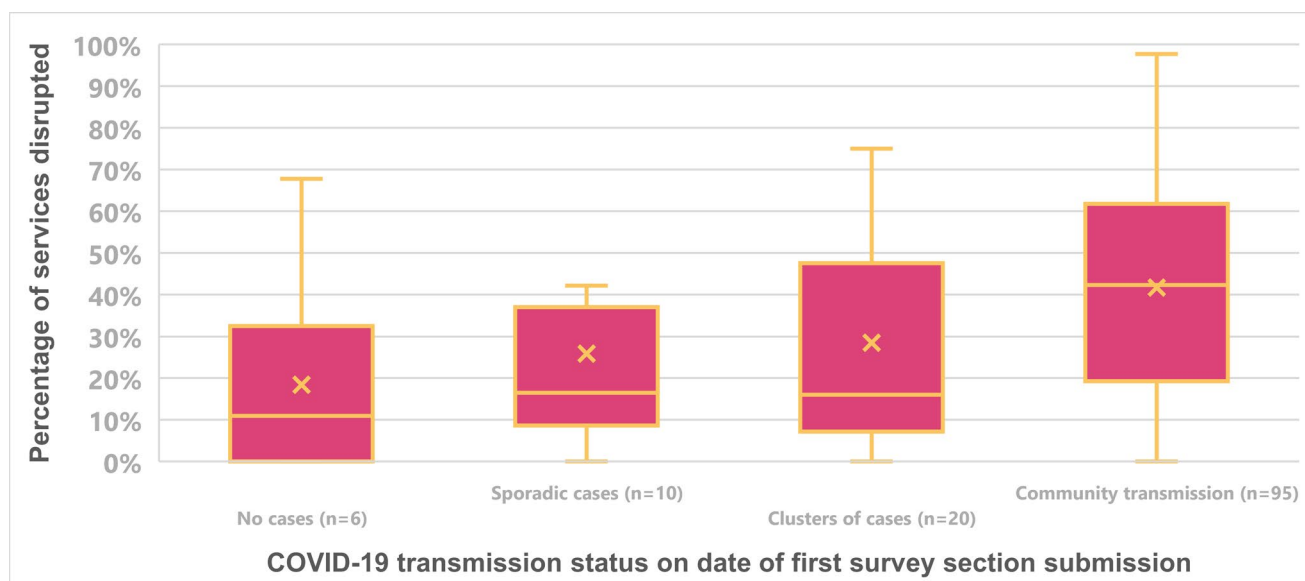


Denominator: represents responses from countries/territories/areas that responded to at least one survey section and reported on disruption levels for at least one service.

X indicates the average percentage of disrupted services per country/territory/area in each income group; the line across the bar in the middle quartiles indicates the median percentage of disrupted services reported per country/territory/area in each income group.

The average percentage of services disrupted across countries was also analysed against countries' COVID-19 transmission status and the average daily case count during the months of survey collection based on [WHO weekly epidemiological update on COVID-19](#) (10). Based on the median value in each of the four groups countries, the level of service disruption was considerably higher in countries with community transmission than in the other three groups with lower levels of transmission. There was however considerable individual variation with each group. The majority of responding countries were classified as having "community transmission", which limits the extent to which comparative analyses can be interpreted across transmission status (see Figure 4, below). In Figure 5, no clear association is seen between the level of service disruptions reported by a country and average daily COVID-19 case count, but further information is needed to understand any potential relationship here as other factors, such as a government's response to the pandemic, could affect the analysis.

Figure 4: Percentage of services disrupted by COVID-19 transmission status (n=131)



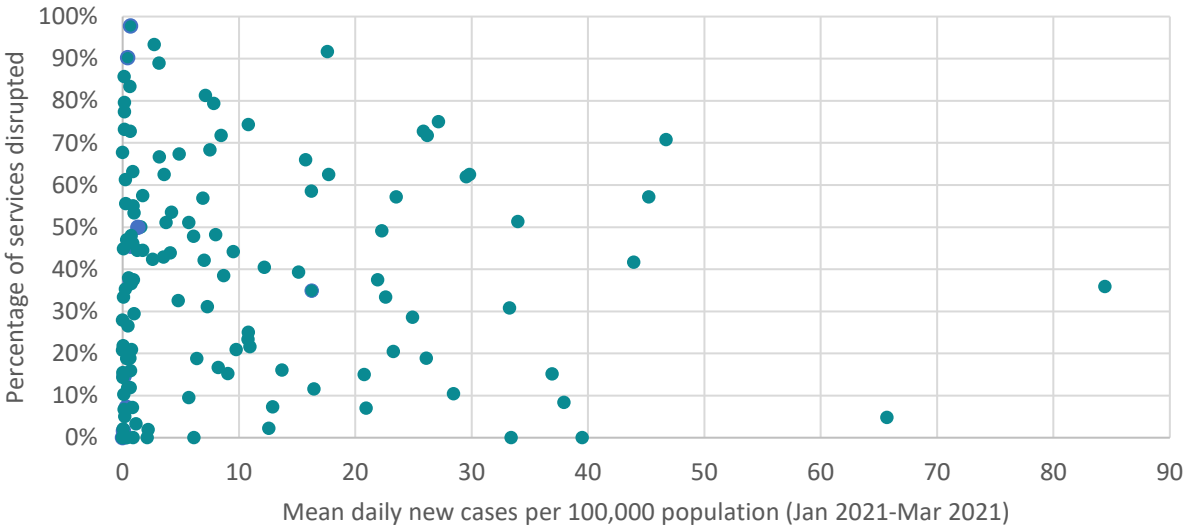
Denominator: represents responses from countries/territories/areas that responded to at least one survey section and reported on disruption levels for at least one service. Countries/territories/areas without a reported COVID-19 transmission status are excluded.

X indicates the average percentage of disrupted services per country in each transmission status group; the line across the bar in the middle quartiles indicates the median percentage of disrupted services reported per country in each transmission status group

As per WHO's [Public health surveillance for COVID-19: interim guidance](#), (11) COVID-19 transmission status categories are defined as the following:

Definition of the categories for transmission pattern Category name	Definition
No (active) cases	No new cases detected for at least 28 days (two times the maximum incubation period), in the presence of a robust surveillance system. This implies a near-zero risk of infection for the general population.
Imported / Sporadic cases	Cases detected in the past 14 days are all imported, sporadic (e.g. laboratory acquired or zoonotic) or are all linked to imported/sporadic cases, and there are no clear signals of further locally acquired transmission. This implies minimal risk of infection for the general population.
Clusters of cases	Cases detected in the past 14 days are predominantly limited to well-defined clusters that are not directly linked to imported cases, but which are all linked by time, geographic location and common exposures. It is assumed that there are a number of unidentified cases in the area. This implies a low risk of infection to others in the wider community if exposure to these clusters is avoided.
Community transmission – level 1 (CT1)	Low incidence of locally acquired widely dispersed cases detected in the past 14 days not linked to specific clusters; transmission may be focused in certain population sub-groups. Low risk of infection for the general population.
Community transmission – level 2 (CT2)	Moderate incidence of locally acquired widely dispersed cases detected in the past 14 days; transmission less focused in certain population sub-groups. Moderate risk of infection for the general population.
Community transmission – level 3 (CT3)	High incidence of locally acquired widely dispersed cases in the past 14 days; transmission not focused in certain population sub-groups. High risk of infection for the general population.
Community transmission – level 4 (CT4)	Very high incidence of locally acquired widely dispersed cases in the past 14 days. Very high risk of infection for the general population.

Figure 5: Mean daily COVID-19 case rates compared to percentage of disrupted services in country (n=131)

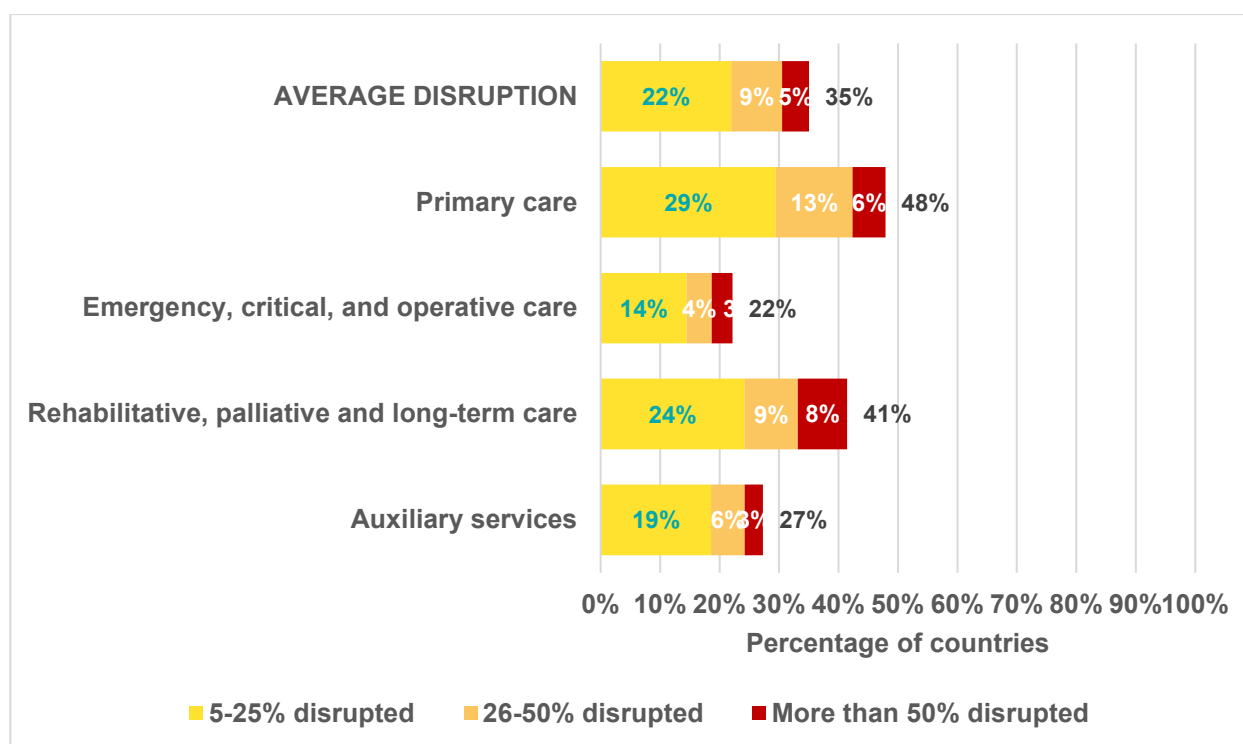


Disruptions across integrated service delivery channels

Section 1 of the survey “Health system functions and cross-cutting services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care” assessed the extent of disruptions across integrated service delivery channels, including in primary care, emergency and critical care, surgical care, rehabilitation, palliative care, long-term care and auxiliary services. Understanding disruptions in these services provides insight into which settings and platforms have been most affected by the pandemic and can help to guide investments.

On average, 35% of 112 countries reported disruptions across all service delivery channels (see Figure 6, below).

Figure 6: Average percentage of disruptions across integrated service delivery channels (n=112)



Primary care and rehabilitative, palliative and long-term care are predominantly affected. As described in WHO’s [Operational Framework for Primary Health Care](#) (12), primary care plays a key role in the health system, providing first-contact, accessible, continuous, comprehensive and coordinated patient-focused care. Primary care sits at the foundation of achieving universal health coverage (UHC), and any disruptions in this setting can cause severe impact across the health system for service delivery and the overall health and well-being of patients. Under primary care, routinely scheduled visits (54% of 98 countries) and health promotion services (53% of 96 countries) were disrupted in more than half of countries. Other essential primary care services, including referrals to specialty care (48% of 91 countries) and visits for undifferentiated symptoms (48% of 90 countries), were also disrupted in nearly half of countries.

Disruptions to potentially life-saving emergency, critical and operative care interventions are of urgent concern as any disruptions in these areas can cause severe near-term indirect consequences on health outcomes.

- 26 (27%) countries reported disruptions to emergency referrals for time-sensitive conditions.
- 18 (19%) countries reported disruptions to inpatient critical care services.
- 16 (19%) countries reported disruptions to ambulance services at the scene.
- 16 (18%) countries reported disruptions to acuity-based triage in emergency units.
- 17 (18%) countries reported disruptions to emergency surgeries.
- 12 (13%) countries reported disruptions to emergency obstetric surgeries.
- 11 (12%) countries reported disruptions to 24-hour emergency room/unit services.
- 8 (9%) countries reported disruptions to urgent blood transfusion services.

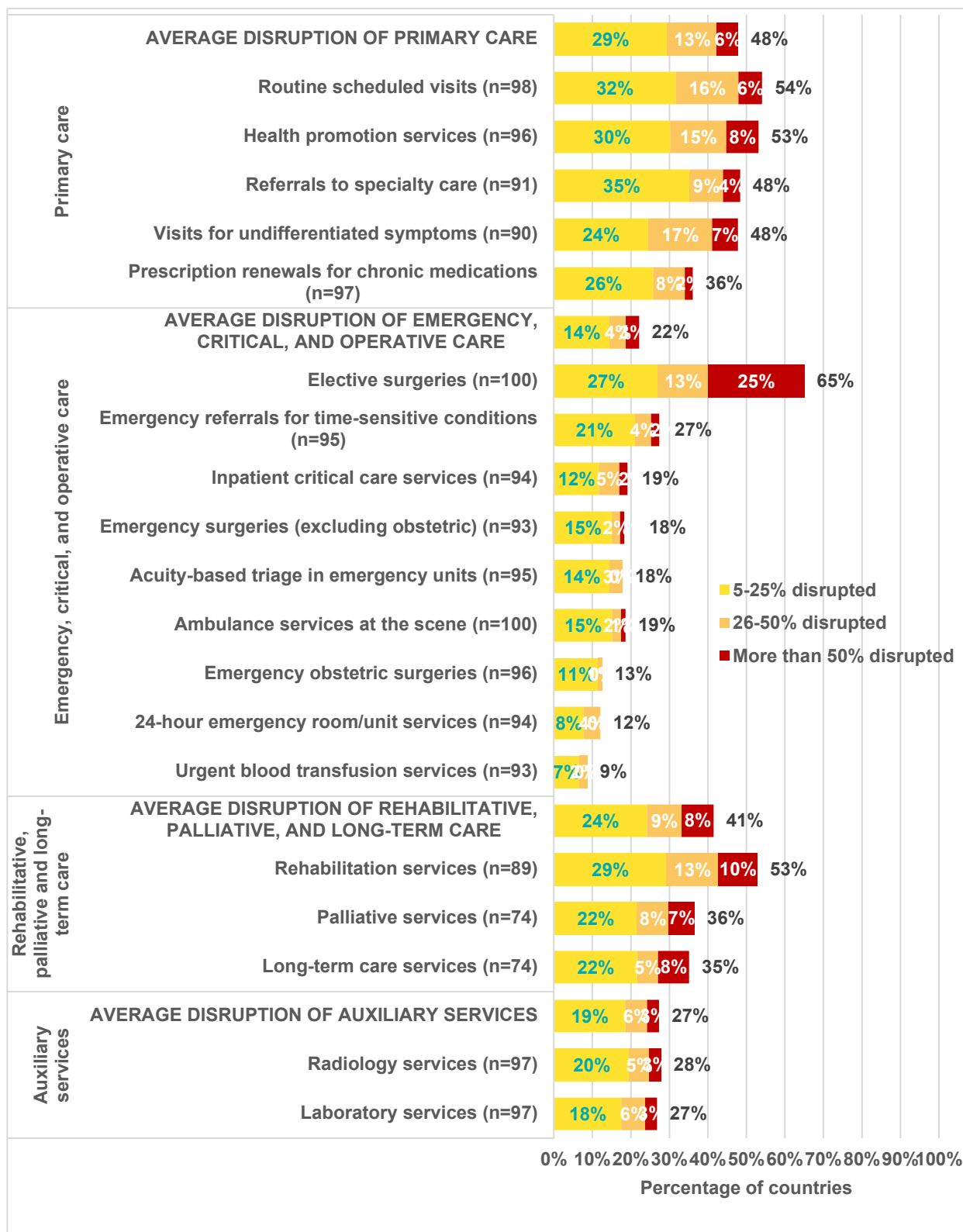
65 (65%) of countries also reported disruptions in elective surgeries, with accumulating consequences as the pandemic is prolonged.

Substantial disruptions have also been reported through the end of the continuum of care. More than half of countries reported disruptions to rehabilitative services, and more than one third of countries reported disruptions to palliative and long-term care services.

Auxiliary services, including laboratory services and radiology services were disrupted in 26 (27%) and 27 (28%) countries respectively (see Figure 7, below).



Figure 7: Service disruptions across integrated service delivery channels (n=112)

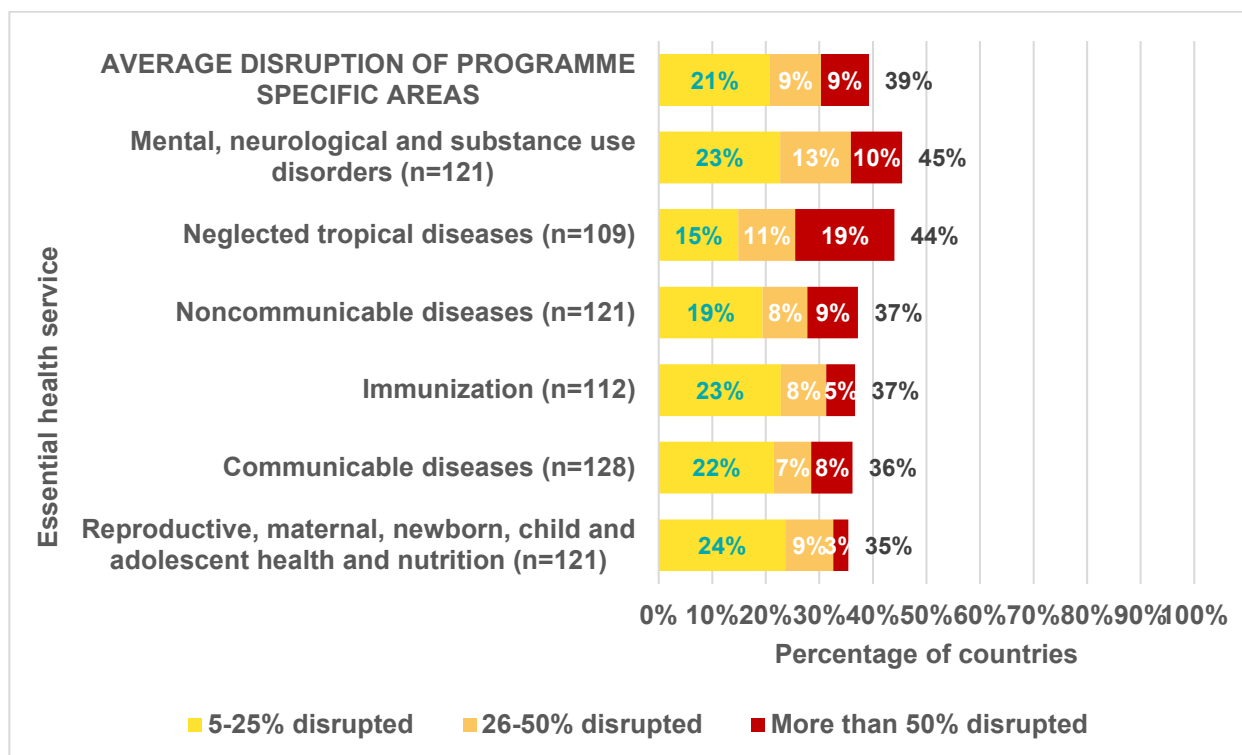


Disruptions to tracer services

To look more deeply into the extent of disruptions across these service delivery channels, key informants also reported the extent of disruption to tracer services for reproductive, maternal, newborn, child and adolescent health, nutrition, immunization, communicable disease, noncommunicable diseases, neglected tropical diseases and mental, neurological and substance use disorders.

On average, 39% of responding countries reported disruptions across all tracer service areas (see Figure 8, below).

Figure 8: Percentage of countries reporting disruptions across tracer service areas



Reproductive, maternal, newborn, child, and adolescent health and nutrition

Continuity of reproductive, maternal, newborn, child and adolescent health (RMNCAH) and nutrition services are critical for the health and well-being of women, newborns, children and adolescents. Disruptions in these areas can result in unintended pregnancies, sexually transmitted diseases, developmental issues and increased health risks.

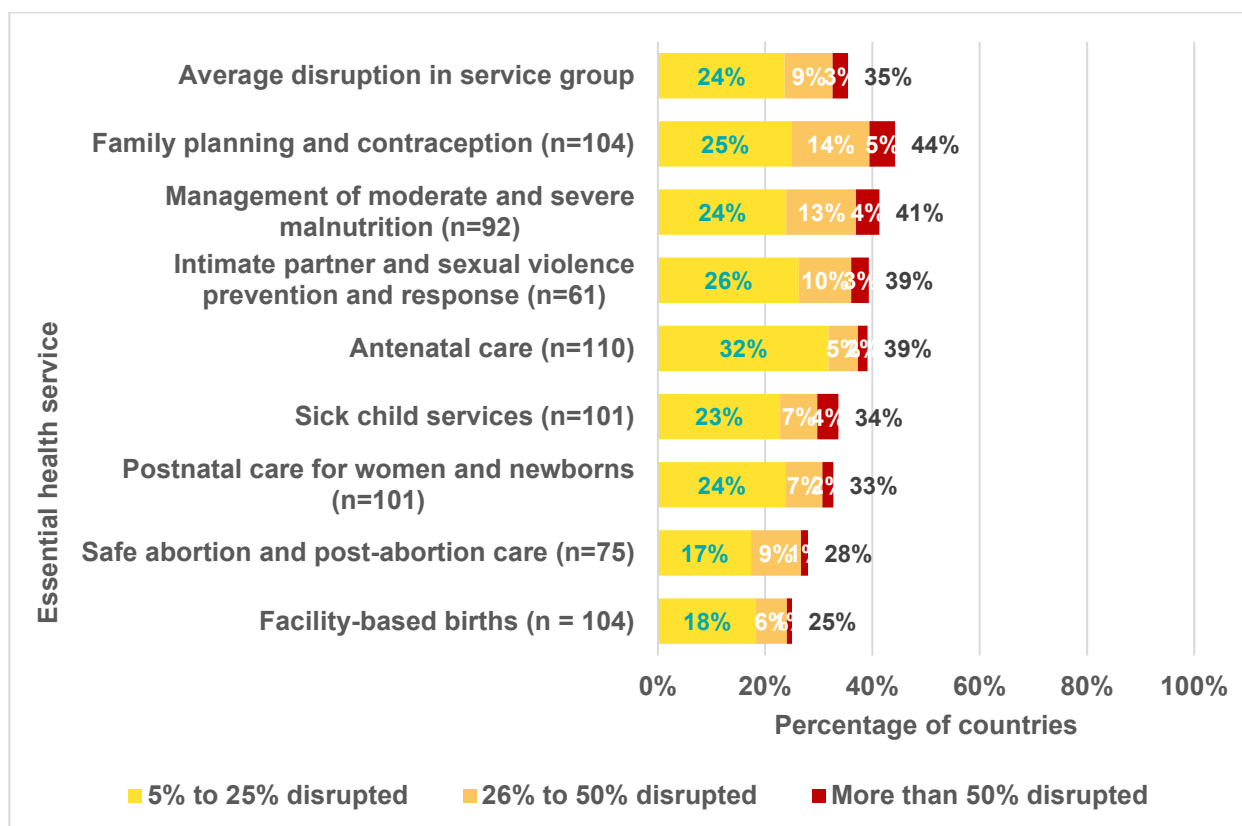
The results show that on average, 35% of countries reported disruptions across RMNCAH and nutrition services. The most frequently disrupted services were family planning and contraception services and management of moderate and severe malnutrition, both of which were disrupted in more than 40% of reporting countries.

Over a third of countries also report disruptions to antenatal care and postnatal care, which are critical health services for ensuring that pregnant women and newborns survive and remain healthy.

Additionally, 26 (25%) countries reported disruptions in facility-based births, 21 (28%) reported disruptions to safe abortion and post-abortion care services, and 24 (39%) reported disruptions to services for intimate partner and sexual violence prevention and response services (see Figure 9, below).

Further information is needed to understand if the reduction in sick child visits (with 34% of 101 countries reporting disruption) reflects actual disruptions or if children are less likely to become ill because of increased measures put in place to prevent the spread of COVID-19, such as hand washing, use of masks, social distancing, lockdowns and not attending school, which can also reduce child illness.

Figure 9: Percentage of countries reporting disruptions in reproductive, maternal, newborn, child and adolescent health and nutrition services

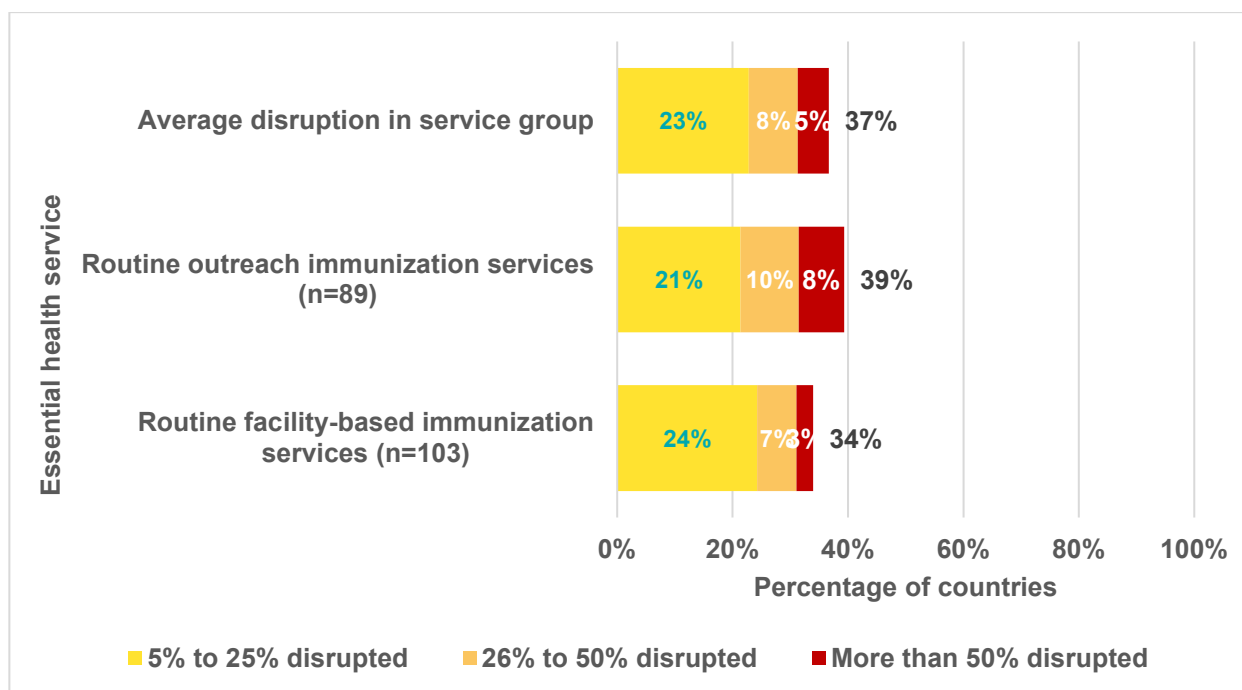


Immunization services

Routine immunization services are also important for newborns and children, and WHO estimates that immunization currently prevents 2-3 million deaths every year from diseases like diphtheria, tetanus, pertussis, influenza and measles (13).

More than one-third of countries reported disruptions to immunization services. Disruptions to routine facility-based and outreach immunization services were reported by 35 (34%) and 35 (39%) countries, respectively (see Figure 10, below).

Figure 10: Percentage of countries reporting disruptions in immunization services



Communicable diseases

Disruptions to communicable disease prevention and treatment services are of particular concern, because they can have an impact on individuals affected by these diseases and who could perpetuate the spread and reach of an illness.

On average, disruptions were reported across outbreak detection and control activities for non-COVID-19 diseases and services for HIV, hepatitis, TB, and malaria in 36% of countries.

Outbreak detection and control activities for non-COVID-19 diseases were disrupted in 23 (25%) countries.

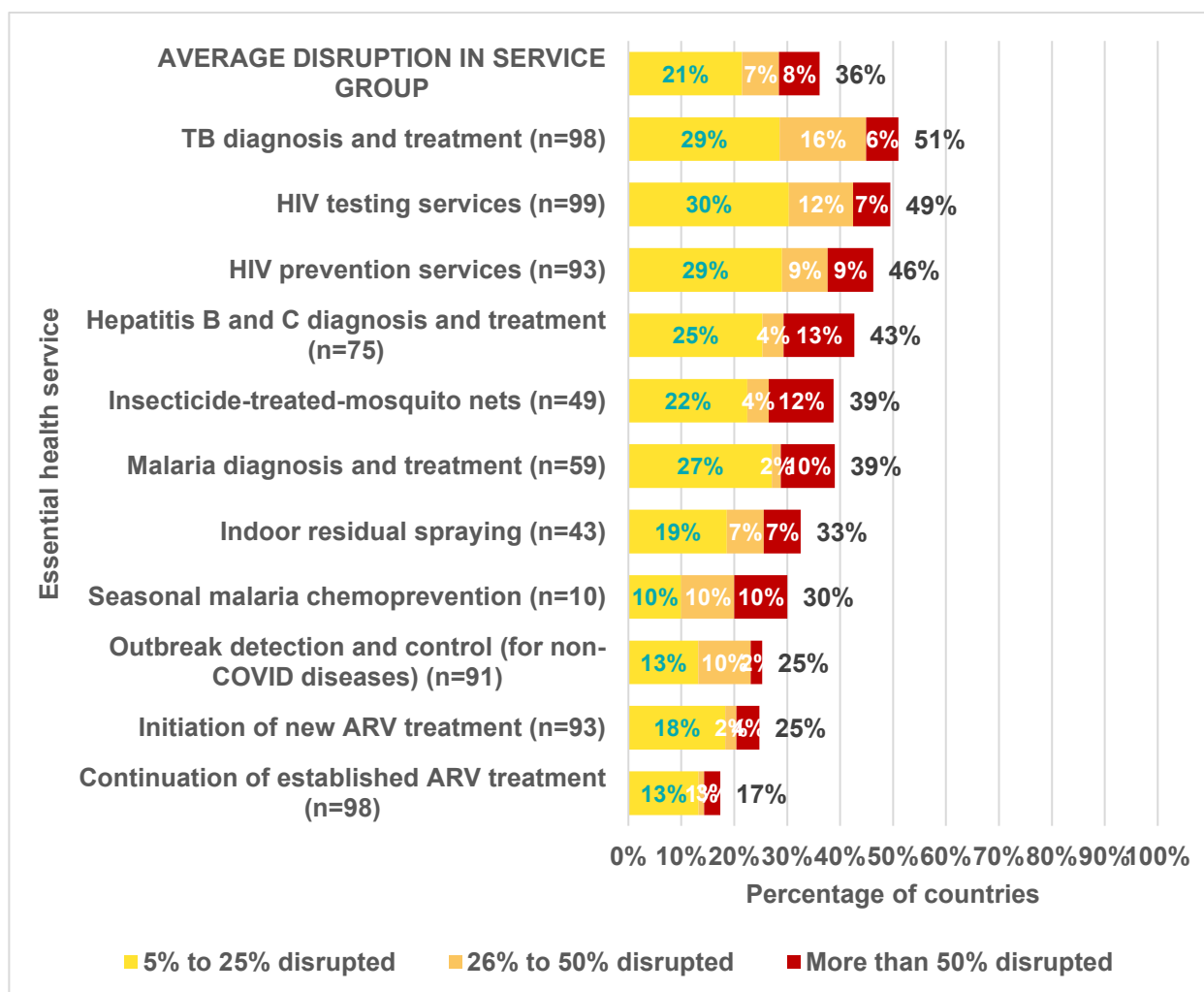
The most frequently reported disruption was to TB diagnosis and treatment, with 50 (51%) countries reporting disruptions, and 6 (6%) countries reporting disruption levels greater than 50%.

HIV services were also disrupted in nearly half of countries, with 49 (49%) countries reporting disruptions to HIV testing services and 43 (46%) countries reporting disruptions to HIV prevention services. 23 (25%) countries reported disruptions to services to initiate new antiretroviral (ARV) treatment, and 17 (17%) reported disruptions to continuation of established ARV treatments.

Hepatitis B and C diagnosis and treatment services were reported as disrupted by 32 (43%) countries.

Between 30-40% of malaria endemic countries reported some level of disruption to malaria diagnostic and treatment services (39% of 59 countries), insecticide-treated-mosquito net (ITN) distribution through mass campaigns (39% of 49 countries), indoor residual spraying (IRS) campaigns (33% of 43 countries) and seasonal malaria chemoprevention (SMC) campaigns (30% of 10 countries). Less than 15% of responding countries had severe disruptions of more than 50% to these services (see Figure 11, below).

Figure 11: Percentage of countries reporting disruptions in communicable disease services



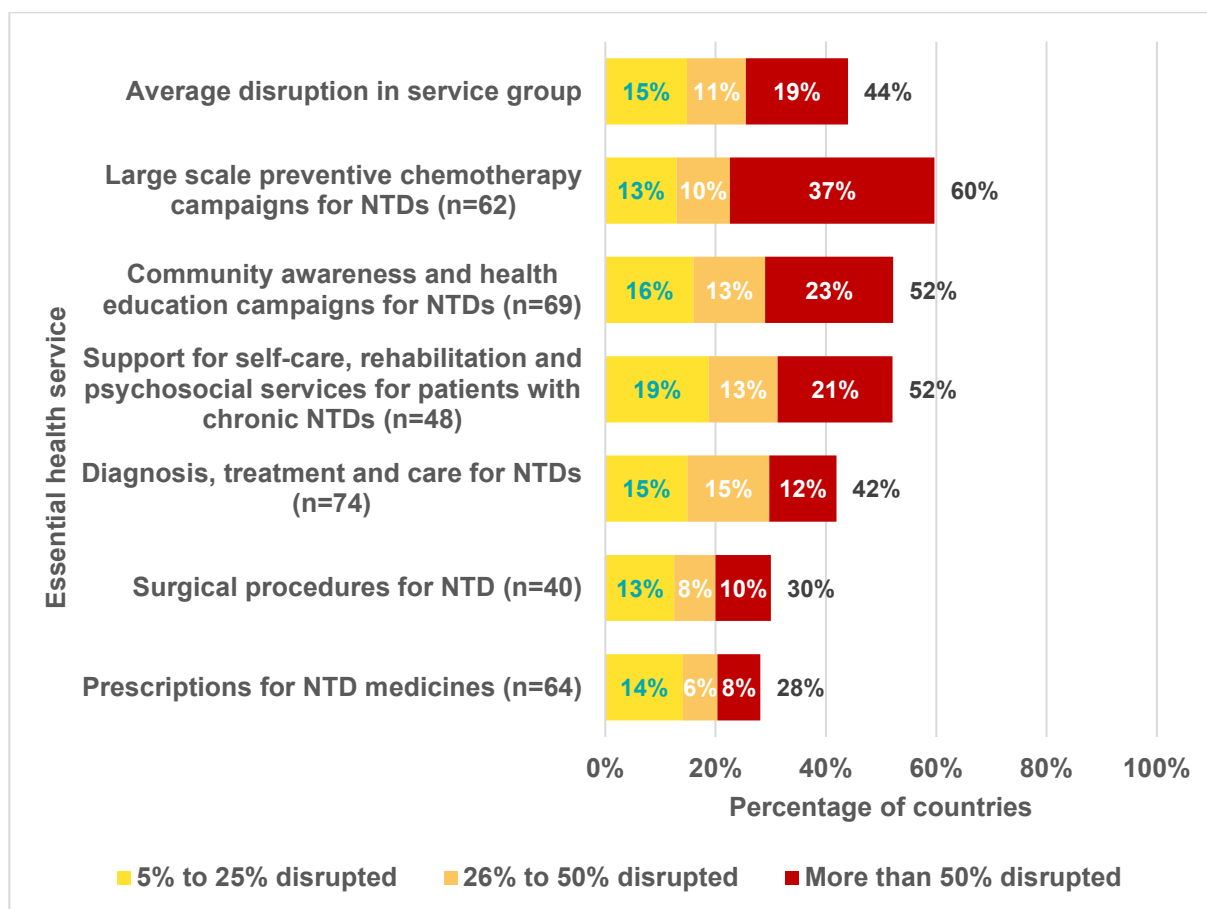
Neglected tropical diseases

Neglected tropical diseases (NTDs) include a diverse group of diseases and disease groups that are mostly communicable and primarily found in tropical and subtropical countries.²

On average, 44% of countries reported disruptions to NTD services. Among the most frequently disrupted services were NTD campaigns.

- 37 (60%) countries reported disruptions of large-scale NTD preventive chemotherapy campaigns (with 23 of these countries reporting disruption levels of more than 50% to campaigns).
- 36 (52%) countries reported disruptions to community awareness and health education campaigns for NTDs.
- 25 (52%) countries also reported disruptions to support for self-care, rehabilitation and psychosocial services for patients with chronic NTDs.
- 31 (42%) countries reported disruptions to routine diagnosis, treatment and care for NTDs.
- 18 (28%) countries reported disruptions to prescription services for NTD medicines.
- 12 (30%) countries reported disruptions to surgical procedures for NTDs (see Figure 12, below).

Figure 12: Percentage of countries reporting disruptions in neglected tropical disease services



² NTDs include: Buruli ulcer, Chagas disease, dengue and chikungunya, dracunculiasis (Guinea-worm disease), echinococcosis, foodborne trematodiasis, human African trypanosomiasis (sleeping sickness), leishmaniasis, leprosy (Hansen's disease), lymphatic filariasis, mycetoma, chromoblastomycosis and other deep mycoses, onchocerciasis (river blindness), rabies, scabies and other ectoparasites, schistosomiasis, soiled-transmitted helminthiasis, snakebite envenoming, taeniasis/cysticercosis, trachoma, and yaws and other endemic treponematoses.

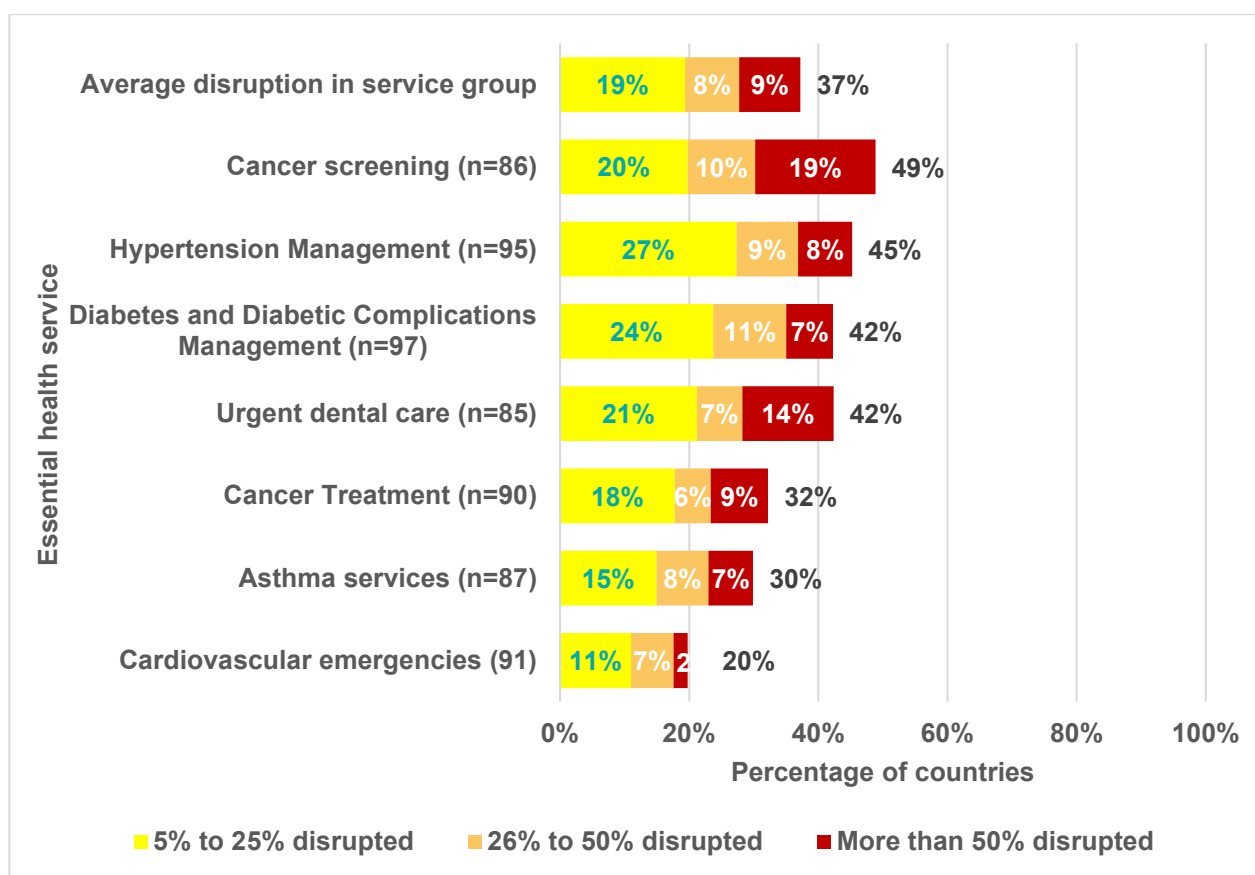
Noncommunicable diseases

Noncommunicable disease (NCD) services are essential for addressing common conditions including cardiovascular diseases, chronic respiratory conditions, diabetes and cancer. Approximately half of countries reported one or more disruptions to essential NCD services.

The most disrupted service was cancer screening, which nearly half of countries (49% of 86 countries) reported as disrupted, and 16 (19%) countries reported as disrupted by more than 50%. Additionally:

- 43 (45%) countries reported disruptions to hypertension management services.
- 41 (42%) countries reported disruptions to services for diabetes management.
- 36 (42%) countries reported disruptions to urgent dental care.
- 29 (32%) countries reported disruptions to cancer treatment services.
- 18 (20%) countries reported disruptions to services for cardiovascular emergencies.
- 26 (30%) countries reported disruptions to asthma services (see Figure 13, below).

Figure 13: Percentage of countries reporting disruptions in noncommunicable disease services



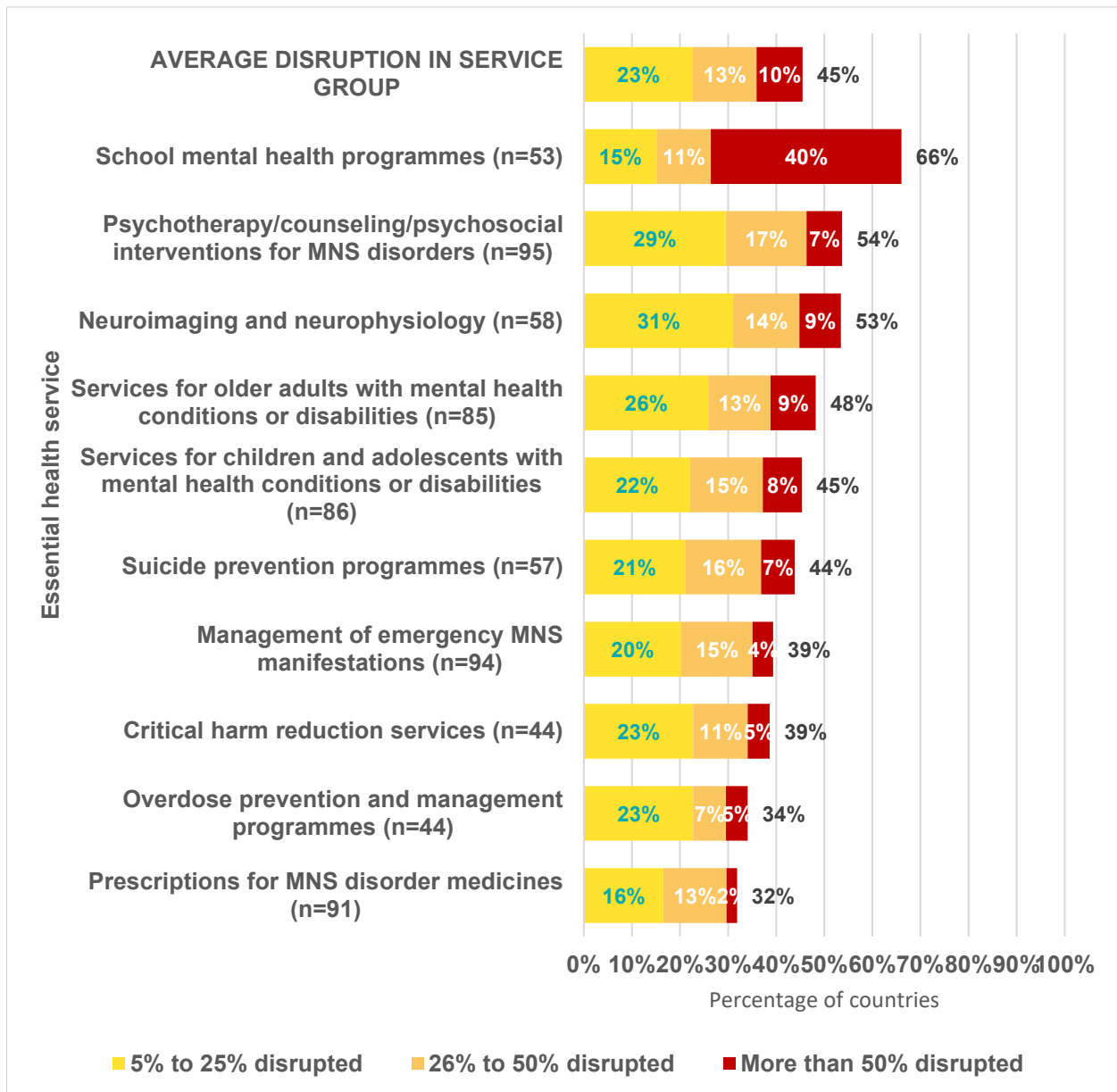
Mental, neurological and substance use disorders

Findings from WHO's [The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment](#) (3) indicate that the majority of countries have identified mental health and psychosocial support as an integral component of their COVID-19 response. The survey revealed serious disruptions to services for mental, neurological and substance use (MNS) disorders in nearly half of all countries. These disruptions provide insight into countries' overall COVID-19 response as well as the continuity of their essential health services.

On average, 45% of countries reported disruptions across MNS prevention and promotion services, diagnosis, treatment and life-saving emergency care:

- 35 (66%) countries reported disruptions to school mental health programmes.
- 51 (54%) countries reported disruptions to psychotherapy, counselling and psychosocial interventions.
- 31 (53%) countries reported disruptions for neuroimaging and neurophysiology services.
- 41 (48%) countries reported disruptions to services for older adults with mental health conditions and disabilities.
- 39 (45%) countries reported disruptions to services for children and adolescents with mental health conditions or disabilities.
- 25 (44%) countries reported disruptions in suicide prevention programmes.
- 37 (39%) countries reported disruptions in the management of emergency MNS manifestations.
- 17 (39%) countries reported disruptions in critical harm reduction services.
- 15 (34%) countries reported disruptions in overdose prevention and management programmes.
- 29 (32%) countries reported disruptions to services to prescribe medicines for MNS (see Figure 14, below).

Figure 14: Percentage of countries reporting disruptions in mental, neurological and substance use disorder services



Disruptions to tracer services across regions and income groups

On average, countries and territories in the Americas and Africa reported greater disruptions across tracer service areas compared to other regions, though interpretation of these findings is limited considering the lower response rates in other regions (see Figures 15-16, below).

Countries in the high-income group reported fewer service disruptions compared to other income groups (see Figures 17-18, below).

Wide variation was seen across regions and income groups in the percentage of countries reporting disruptions across all tracer service areas.

Figure 15: Average percentage of countries reporting disruptions across tracer service areas by WHO region

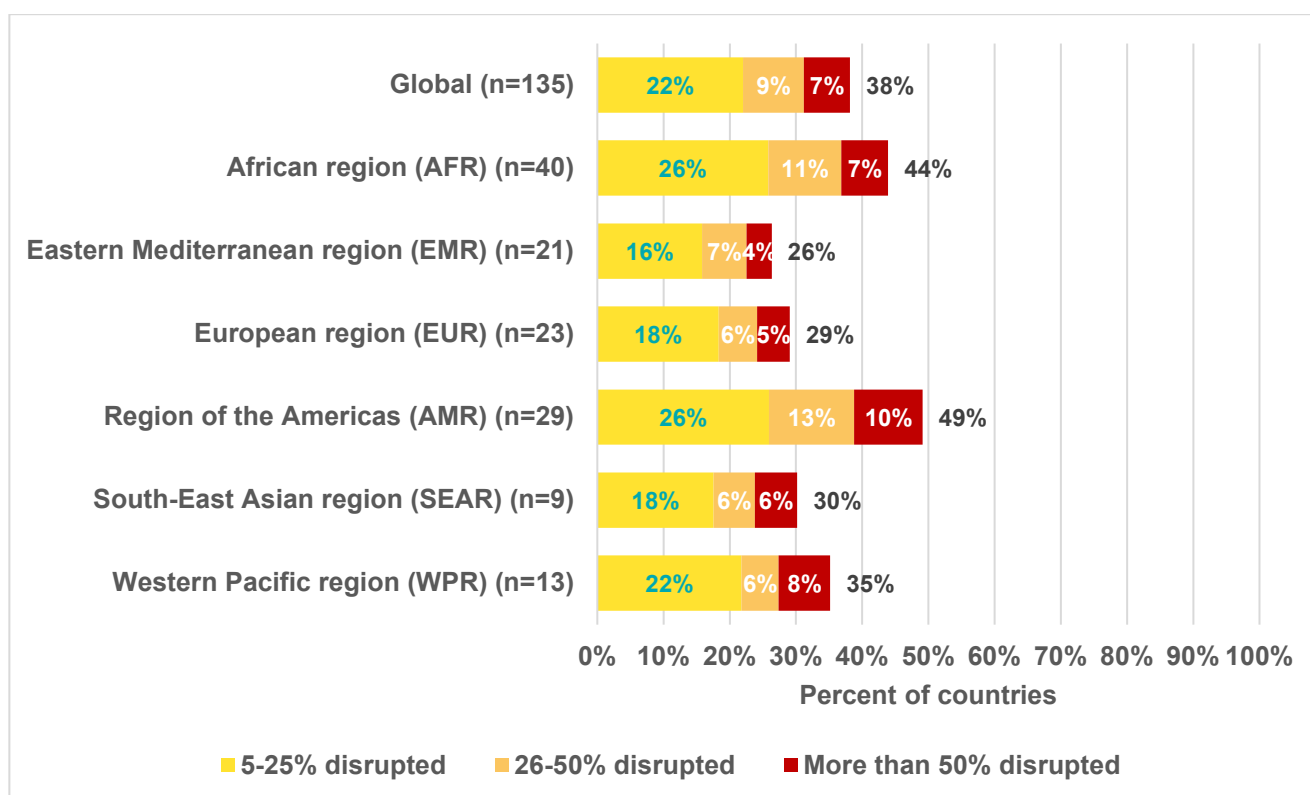


Figure 16: Average percentage of countries reporting disruptions by tracer service area across WHO regions

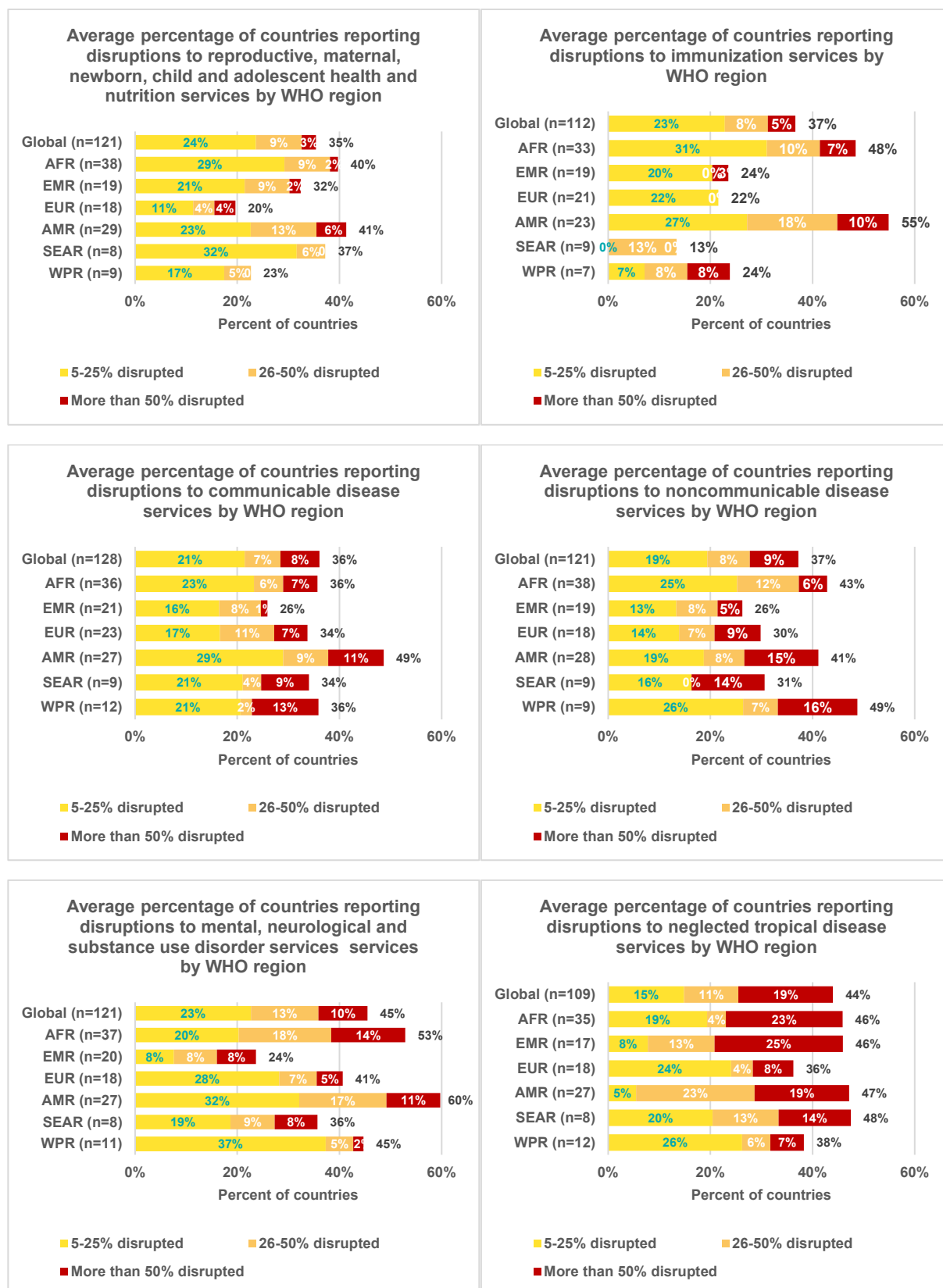


Figure 17: Percentage of countries reporting disruptions across tracer service areas by income group

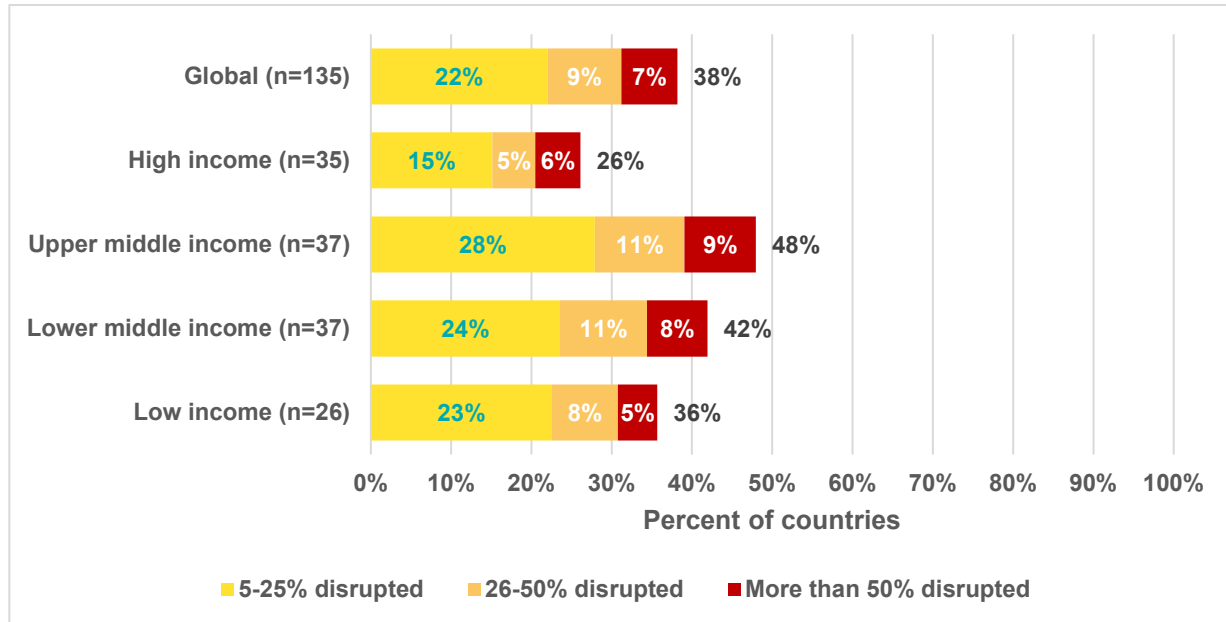
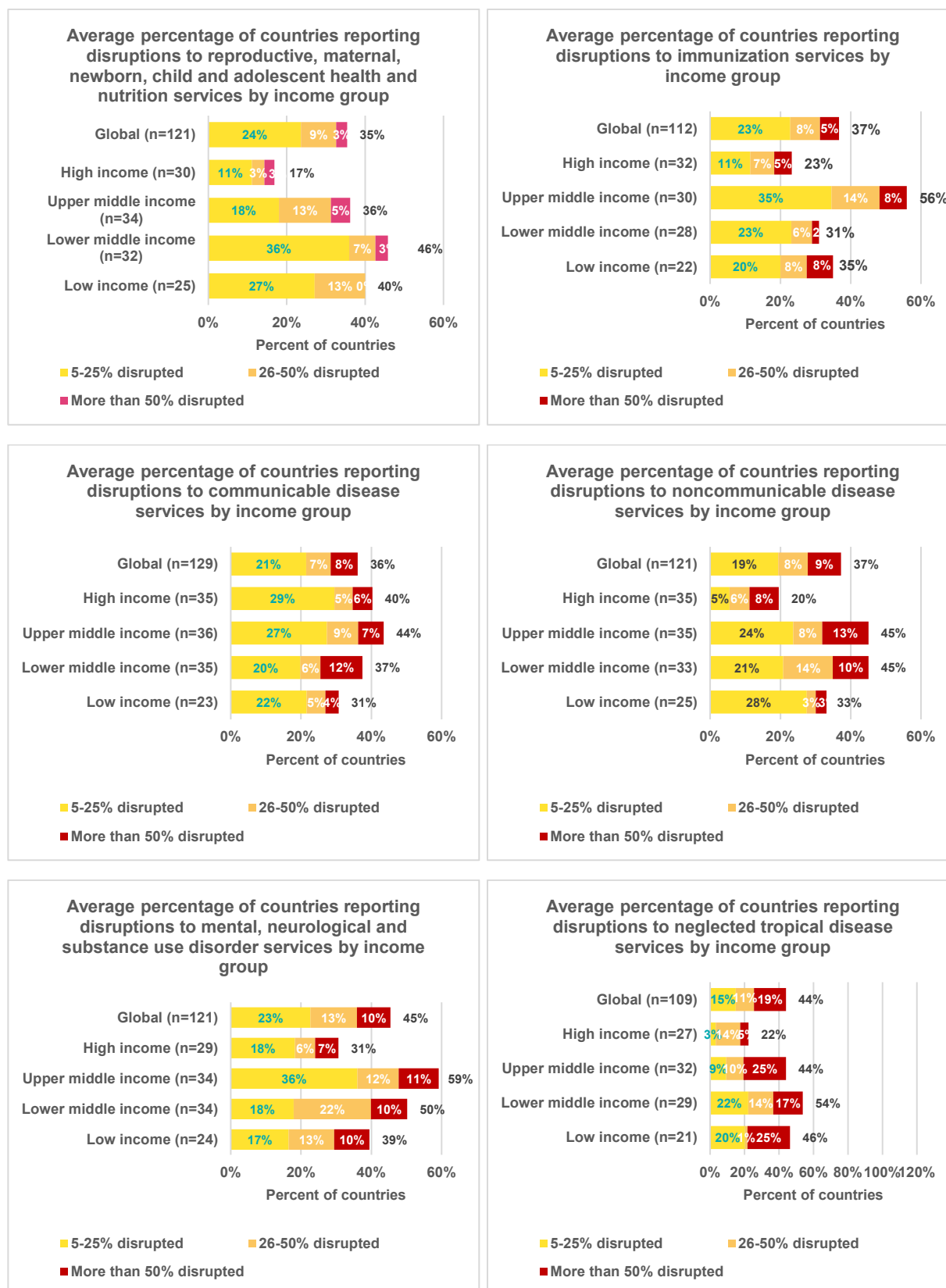


Figure 18: Average percentage of countries reporting disruptions by tracer service area across income groups



Reasons for service disruptions

Figure 19 shows the mix of demand and supply side factors responsible for disruption to services.

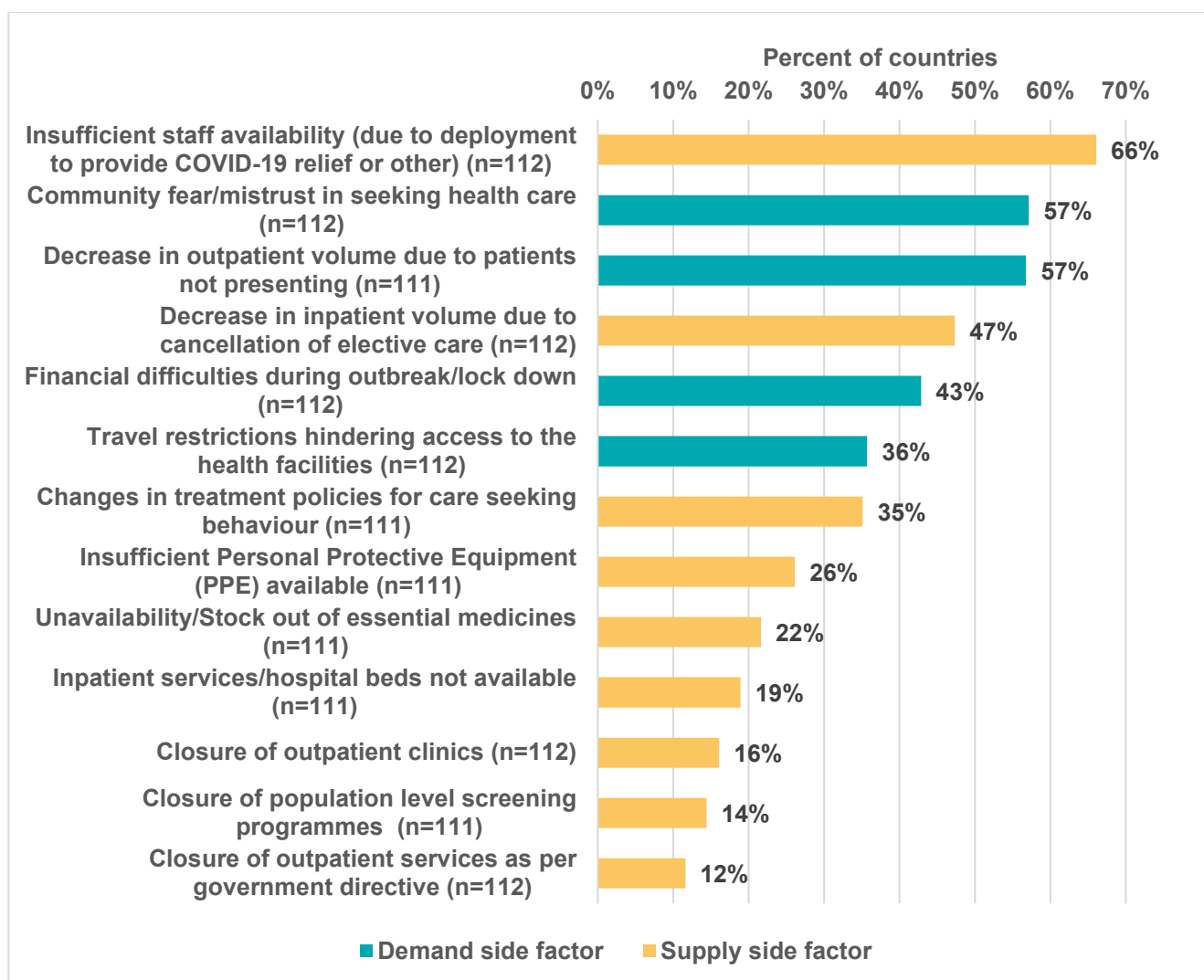
On the supply side, the following causes were most frequently reported:

- insufficient staff availability, for example due to deployment of staff to COVID-19 or other causes (66% of 112 countries);
- cancellation of elective care (47% of 112 countries);
- changes in treatment policies for care-seeking behaviours (35% of 111 countries); and
- insufficient personal protective equipment availability (26% of 111 countries).

Demand-side factors were among the most mentioned causes, including:

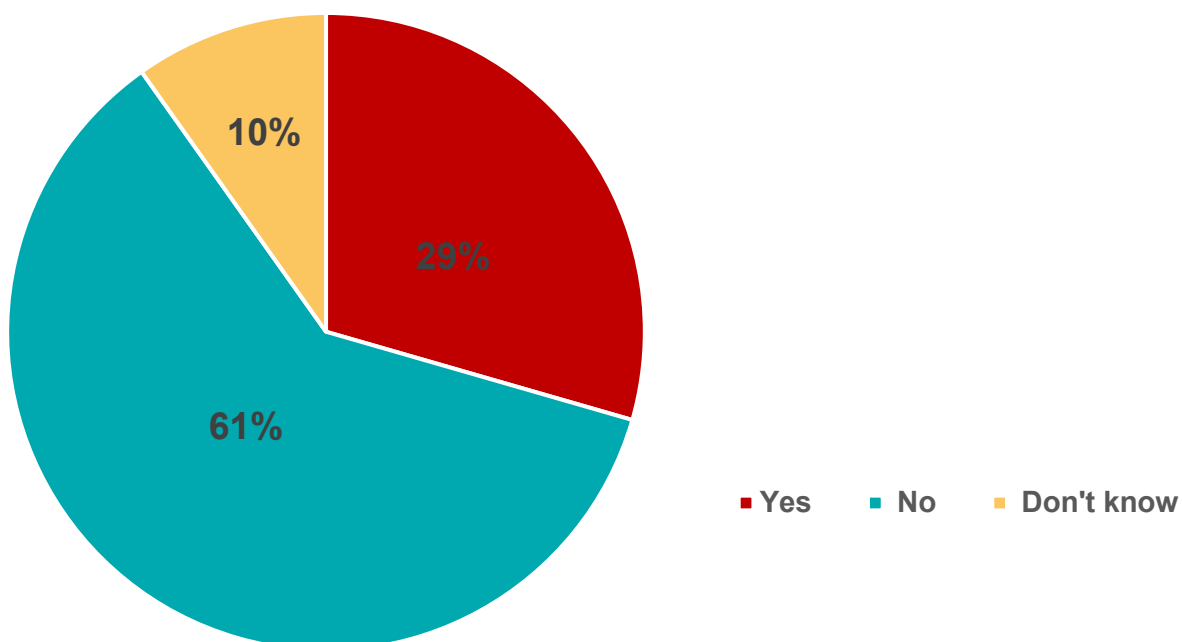
- Community fear and mistrust in seeking health care (57% of 112 countries);
- patients not presenting to outpatient care (57% of 111 countries);
- perceptions that financial difficulties during the outbreak were affecting attendance (43% of 112 countries); and
- perceptions that travel restrictions were hindering access to care (36% of 112 countries).

Figure 19: Reasons for service disruptions



Functional supply chain systems are critical to ensure that necessary health products are available in the right quantities for delivery of essential health services. Disruptions across supply chain systems can limit capacities across the continuum of care. Further to the reasons listed above, nearly one third of countries have reported disruption to in-country supply chain systems during the three months prior to survey submission (see Figure 20, below).

Figure 20: Percentage of countries reporting a disruption in supply-chain (n=112)

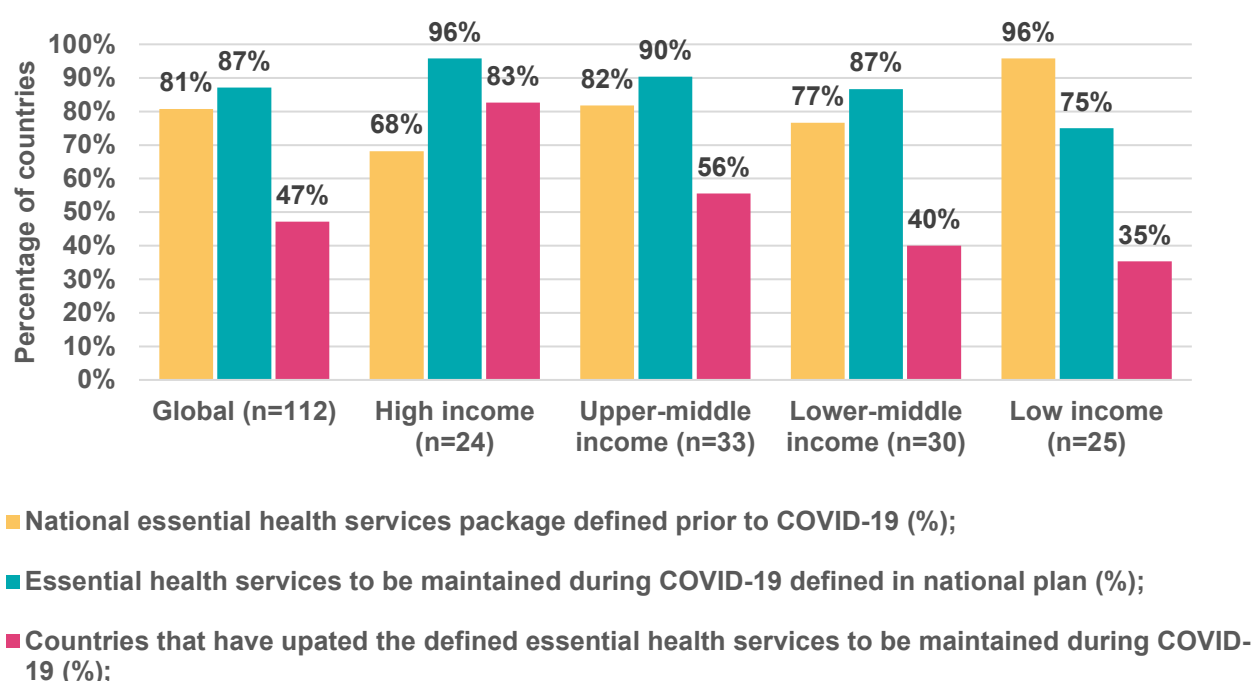


Responsiveness to mitigate service disruptions

Policies, plans, and mechanisms to support continuity of essential health services

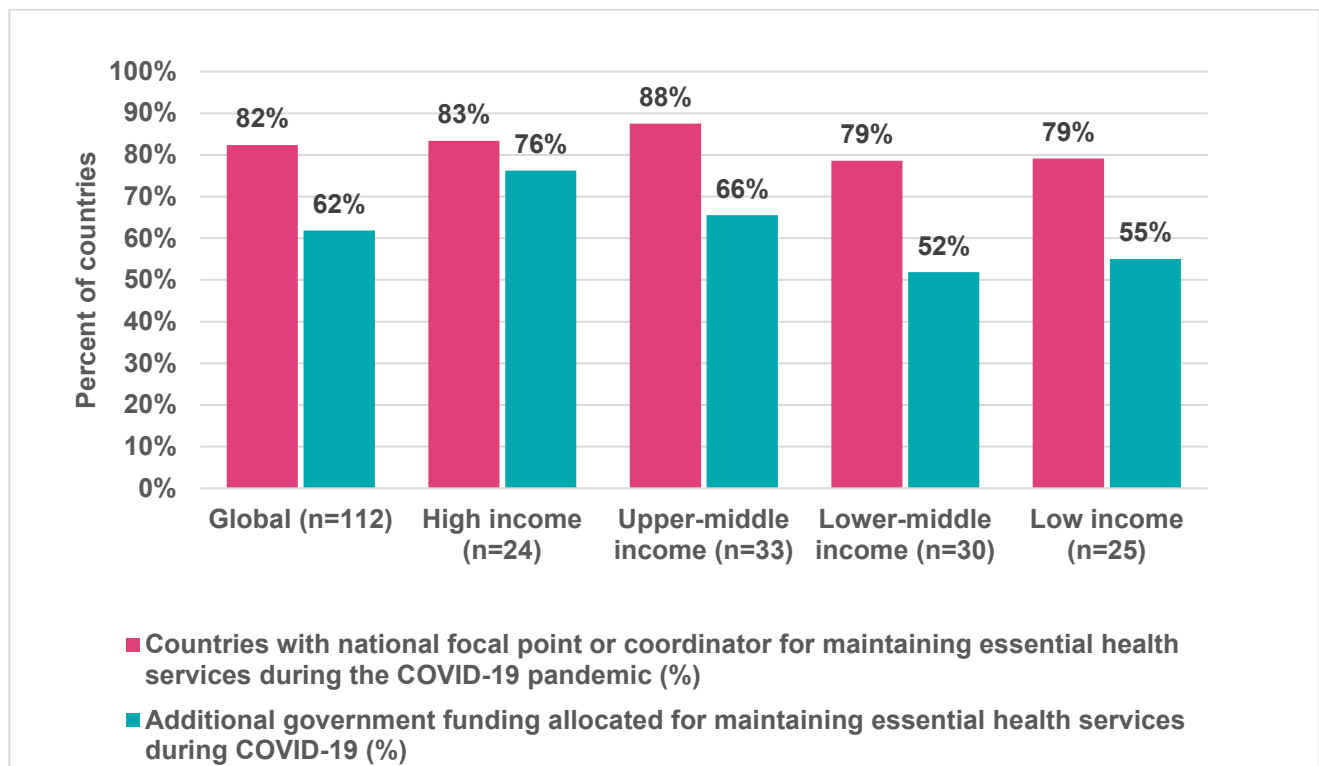
Most countries have established policies, plans and mechanisms to support the maintenance of essential health services during the COVID-19 pandemic. The survey found that approximately 9 out of 10 responding countries have defined a core set of essential health services to be maintained during the COVID-19 pandemic, and almost half have updated or revised that list of services since the start of the pandemic. Countries in higher income groups were more likely to have defined and/or updated services to be maintained during the pandemic as compared to those in lower income groups (see Figure 21, below).

Figure 21: Countries with defined national essential health services to be maintained during the COVID-19 pandemic (by income group)



Additionally, 82% of countries have designated a national focal point or coordinator responsible for maintaining essential health services during the COVID-19 pandemic, and nearly two thirds have allocated additional funds to support continuity of essential health services. Allocation of additional funding was more frequently reported in upper-middle income and high-income countries (see Figure 22, below).

Figure 22: Countries with designated focal points/coordinators and additional government funding for maintaining EHS (by income group)

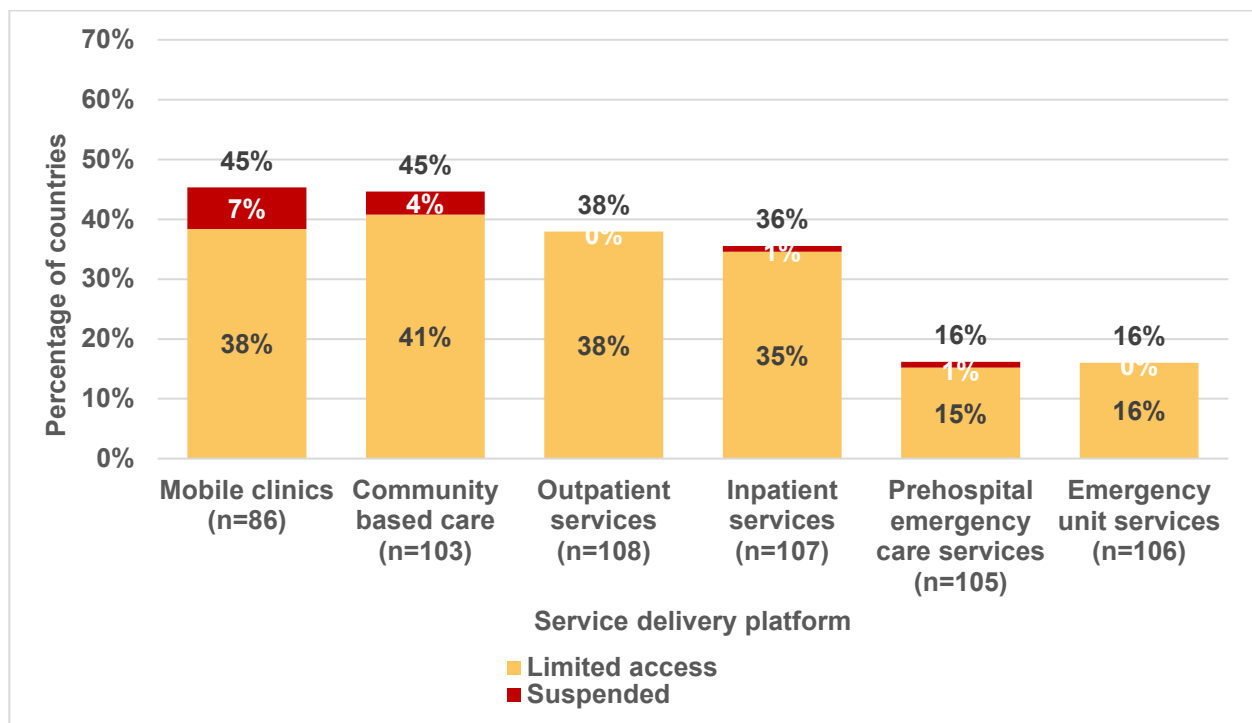


Strategic modifications to service delivery and essential public health functions

To some extent, disruptions can be attributed to intentional strategic changes to service delivery platforms and public health functions in the context of the pandemic.

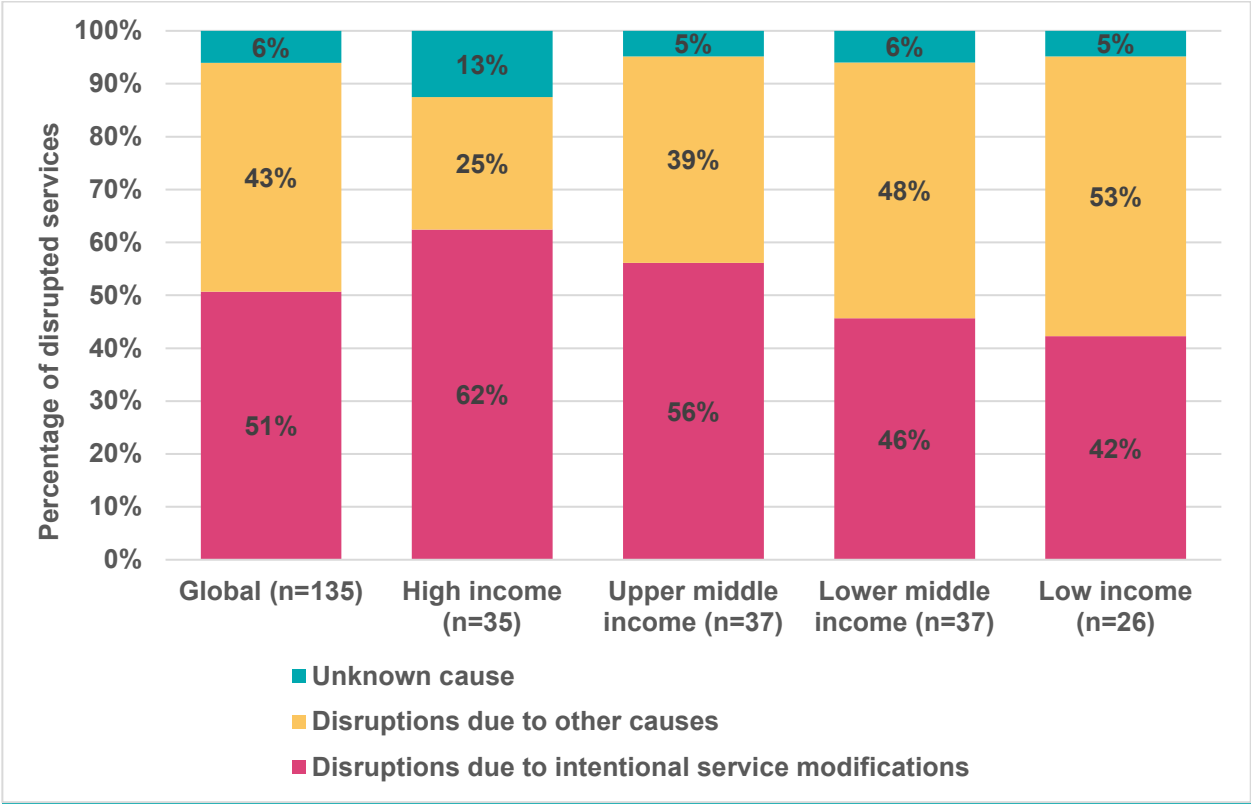
Nearly half of countries implemented government policies to scale back access to at least one service delivery platform at some point during the reported period. One-third or more countries have limited or suspended access to mobile clinics (45% of 86 countries), community-based services (45% of 103 countries), outpatient services (38% of 108 countries) and inpatient services (36% of 107 countries). Access to pre-hospital emergency care services and emergency unit services has also been scaled back in 16% of responding countries (see Figure 23, below). The most common suspension was to mobile clinics.

Figure 23: Government policies in relation to service delivery platforms (n=112)



As countries have responded to COVID-19 surges, they also have implemented changes to delivery of specific services to ensure the safety of health workers and users, thereby mitigating health systems collapse. In the survey, overall service disruptions were broken down into unintentional disruptions and intentional disruptions, such as those due to strategic service delivery modifications (e.g. intentionally scaling back or temporarily suspending services). About half of the reported disruptions (51%) worldwide have resulted from intentional modifications. Disruptions are more frequently the result of strategic suspensions or modifications in high-income countries (62%) (see Figure 24, below).

Figure 24: Percentage of disruptions to tracer services due to intentional modifications (by income group)

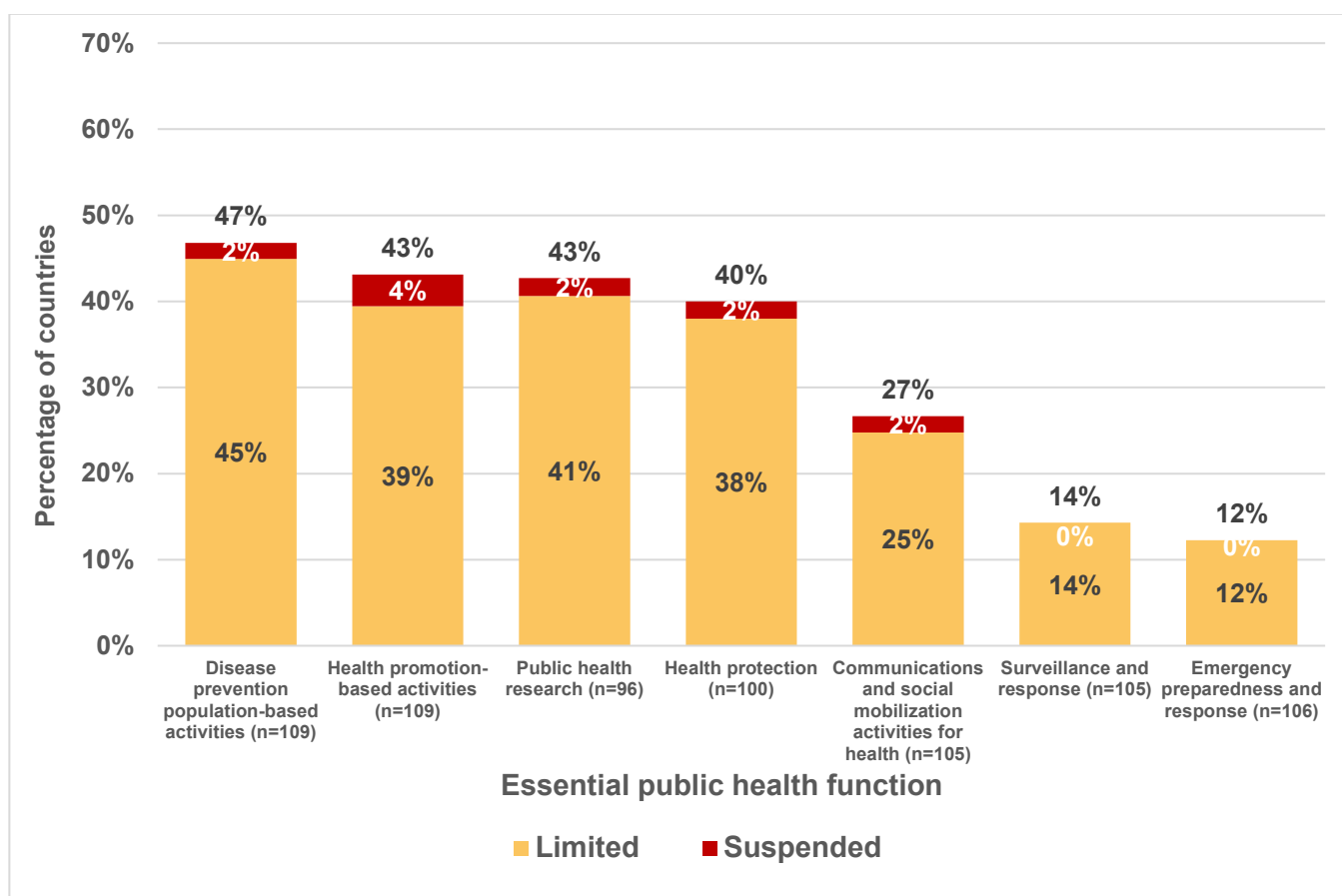


Denominator: represents responses from countries/territories that responded to at least one survey section and reported on disruption levels for at least one service.

Intentional changes were also reported across all essential public health functions and activities. Nearly half of countries limited or suspended at least one essential public health function or activity.

- 51 (47%) countries have scaled back population-based disease prevention activities.
- 47 (43%) countries have scaled back population-based health promotion activities.
- 41 (43%) countries have scaled back public health research activities.
- 40 (40%) countries have scaled back population-based health protection activities.
- 28 (27%) countries have scaled back communications and social mobilization activities for health.
- 15 (14%) countries have scaled back surveillance and response functions.
- 13 (12%) countries have scaled back emergency preparedness and response activities (see Figure 25, below).

Figure 25: Government policies in relation to essential public health functions (n=112)



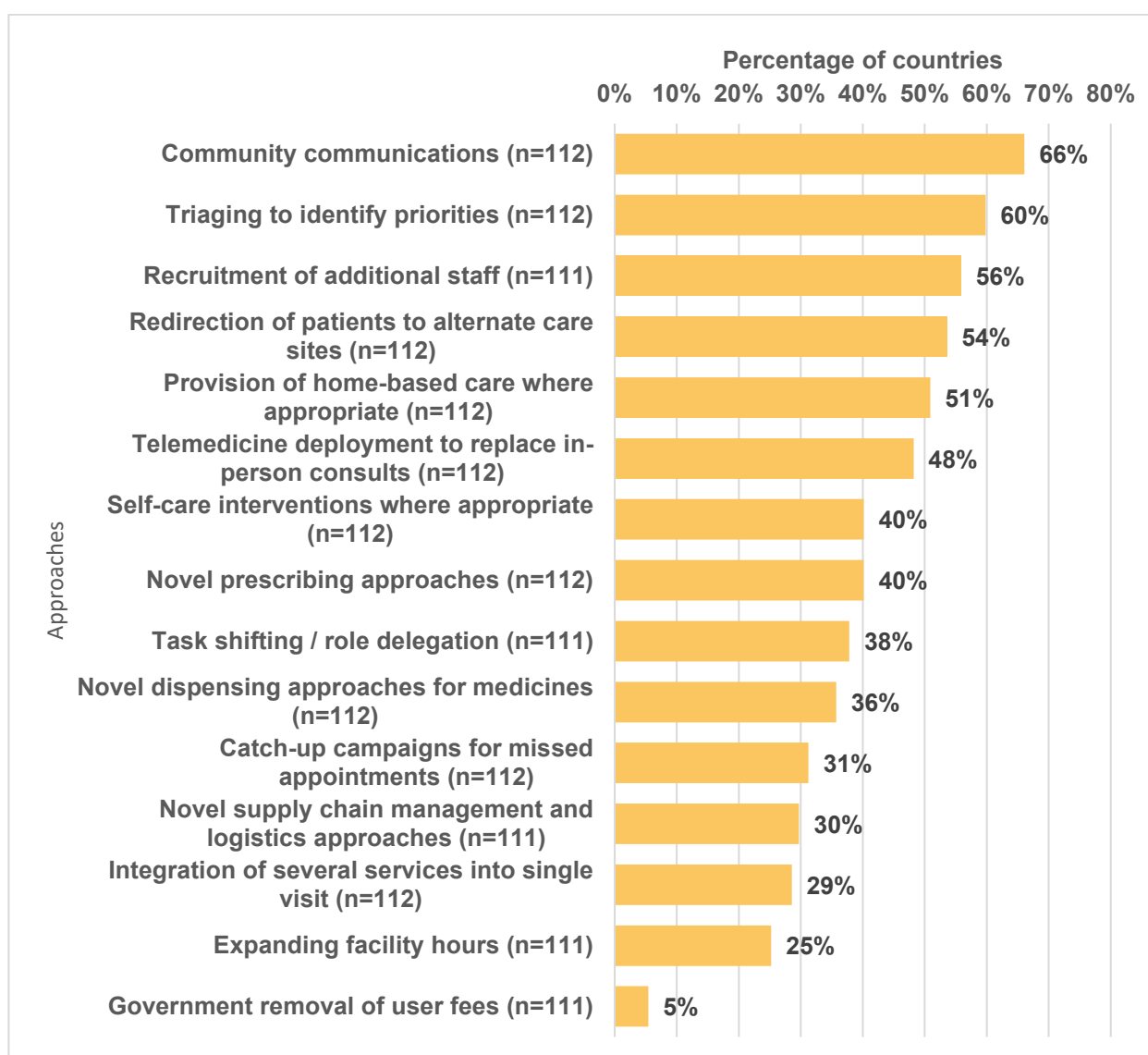
Mitigation strategies and approaches

The majority of countries are implementing approaches to mitigate service disruptions. Among the most commonly reported approaches are:

- use of community communications (66% of 112 countries);
- triaging to identify priorities (60% of 112 countries);
- recruitment of additional staff (56% of 111 countries);
- redirection of patients to alternate care sites (54% of 112 countries);
- provision of home-based care (51% of 112 countries); and
- replacement of in-person consultations with telemedicine (48% of 112 countries).

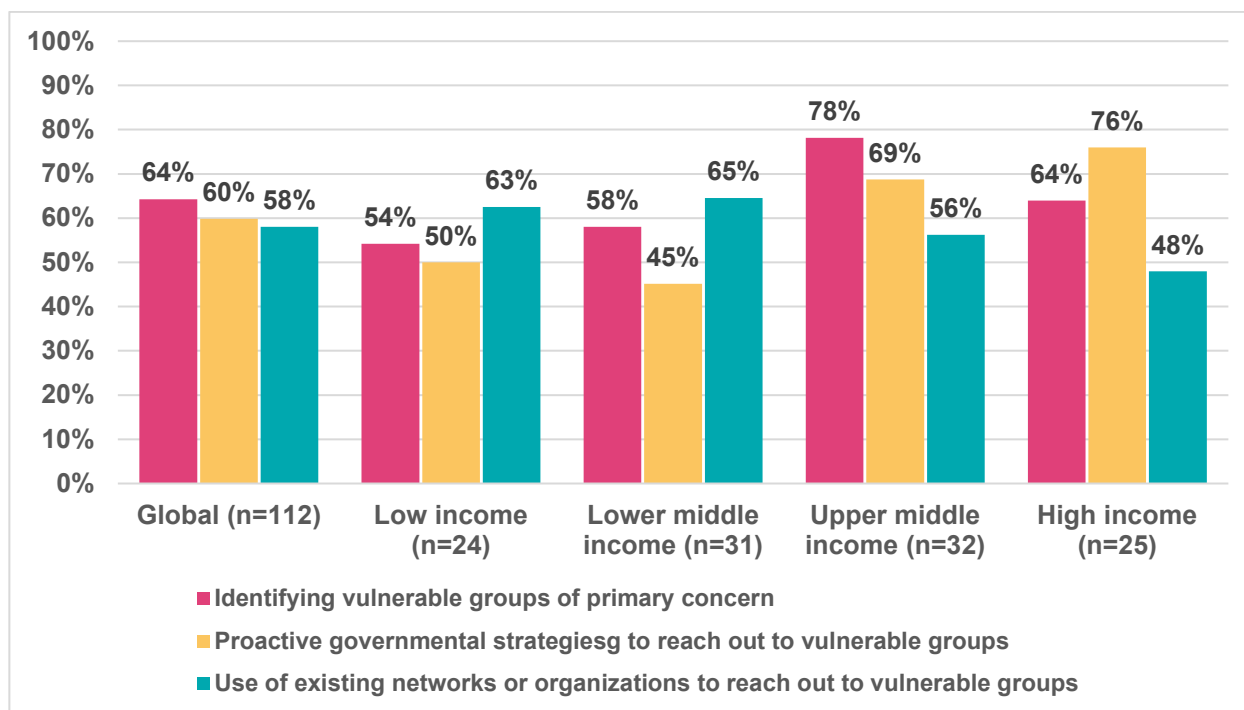
Only 5% of 111 countries have removed user fees to support continuity of essential health services (see Figure 26, below).

Figure 26: Approaches for overcoming disruptions



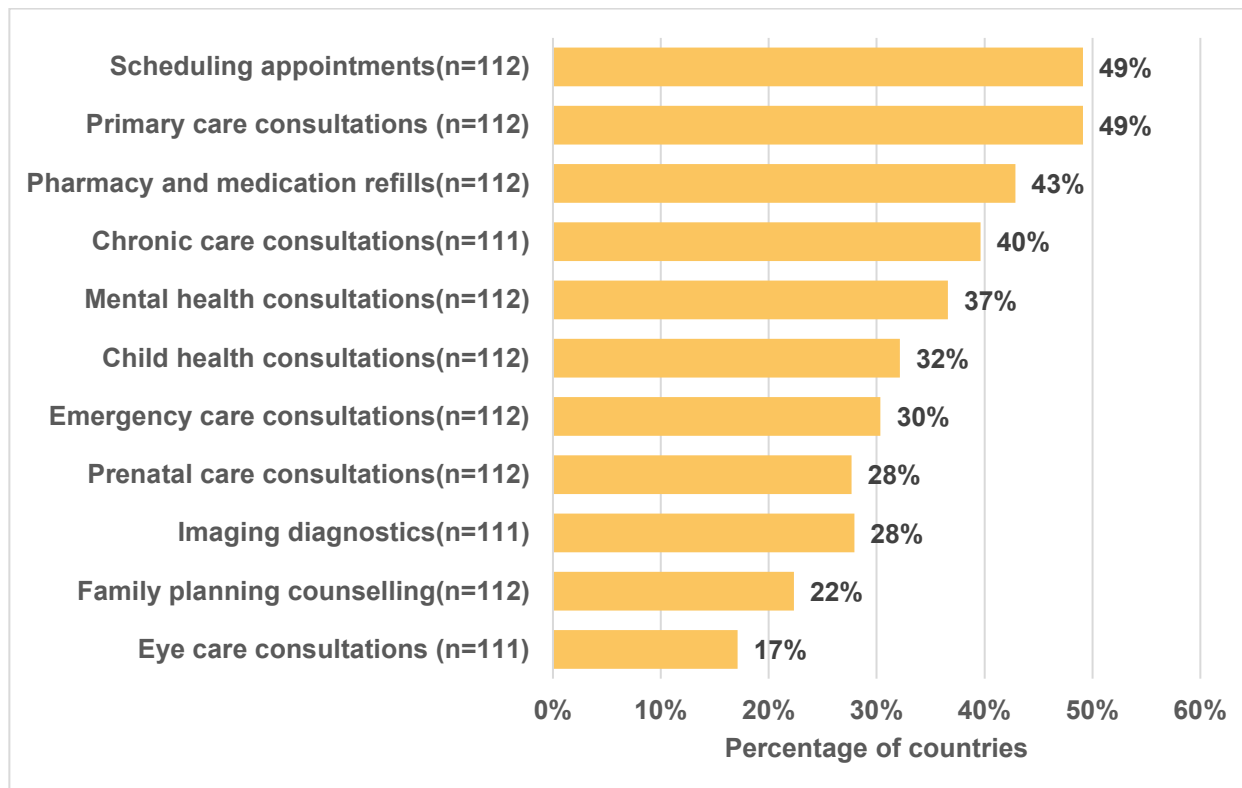
Many countries are also implementing approaches to target and ensure access to care for specific vulnerable groups. High- and middle-income countries are implementing these approaches slightly more often than countries in low- and lower-middle income groups (see Figure 27, below).

Figure 27: Countries using approaches to ensure access to care for vulnerable groups



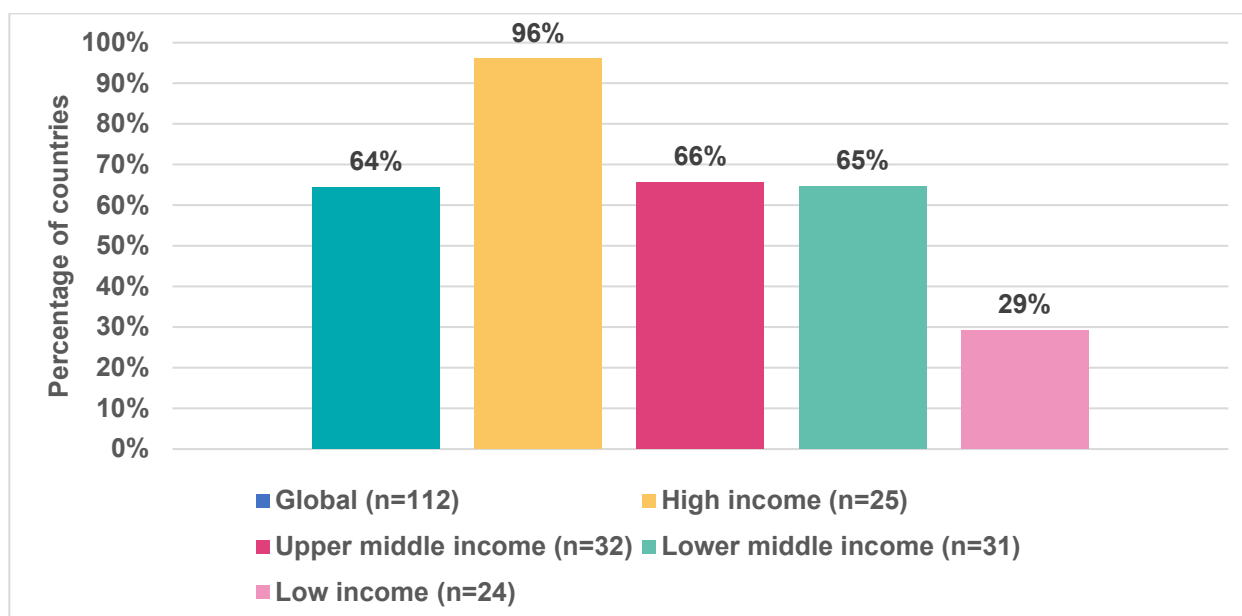
Nearly half of countries have implemented telehealth technologies to support service delivery. Most frequently, countries are using these technologies to support the scheduling of medical appointments (49% of 112 countries), for primary care consultations (49% of 112 countries) and for pharmaceutical medication refills (43% of 112 countries) (see Figure 28, below).

Figure 28: Percentage of countries reporting use of telehealth technologies to support service delivery



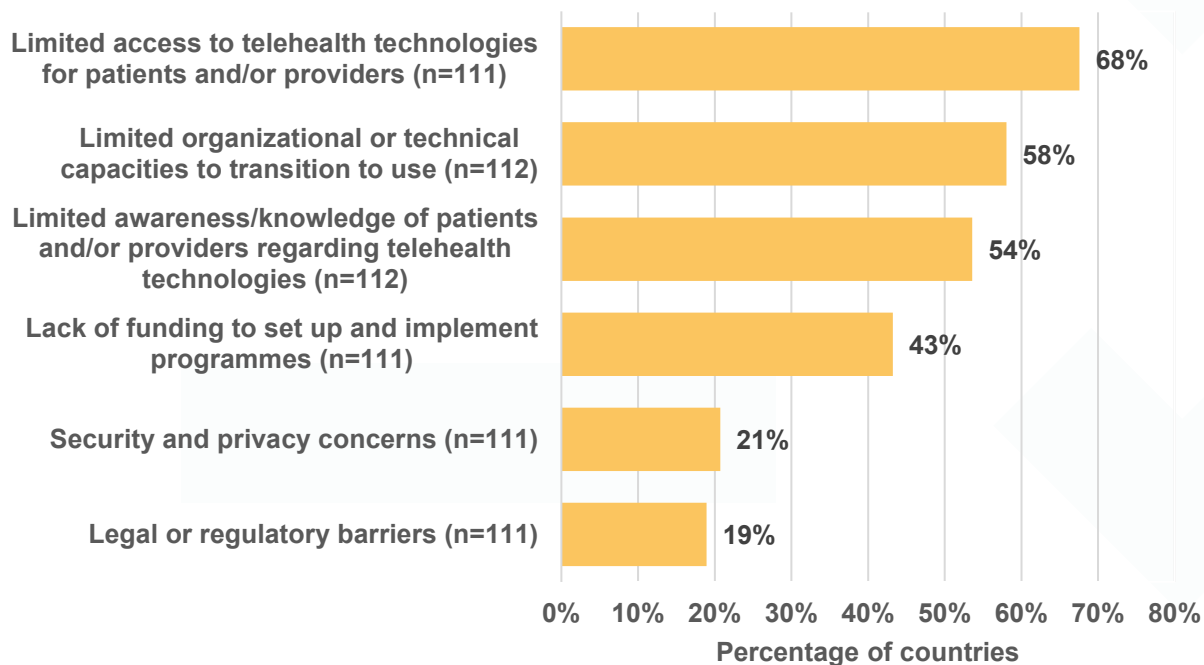
High income countries are implementing telehealth technologies more frequently than lower income countries (see Figure 29, below).

Figure 29: Percentage of countries reporting use of telehealth technologies to support service delivery



Still, many countries are reporting barriers to the use of telehealth technologies. Limited access (68% of 111 countries) and limited technical capacities (58% of 112 countries) are the most commonly reported barriers. Limited awareness and knowledge about available technologies were reported as a barrier to use in 54% of 112 countries (see Figure 30, below).

Figure 30: Percentage of countries reporting barriers to use of telehealth technologies



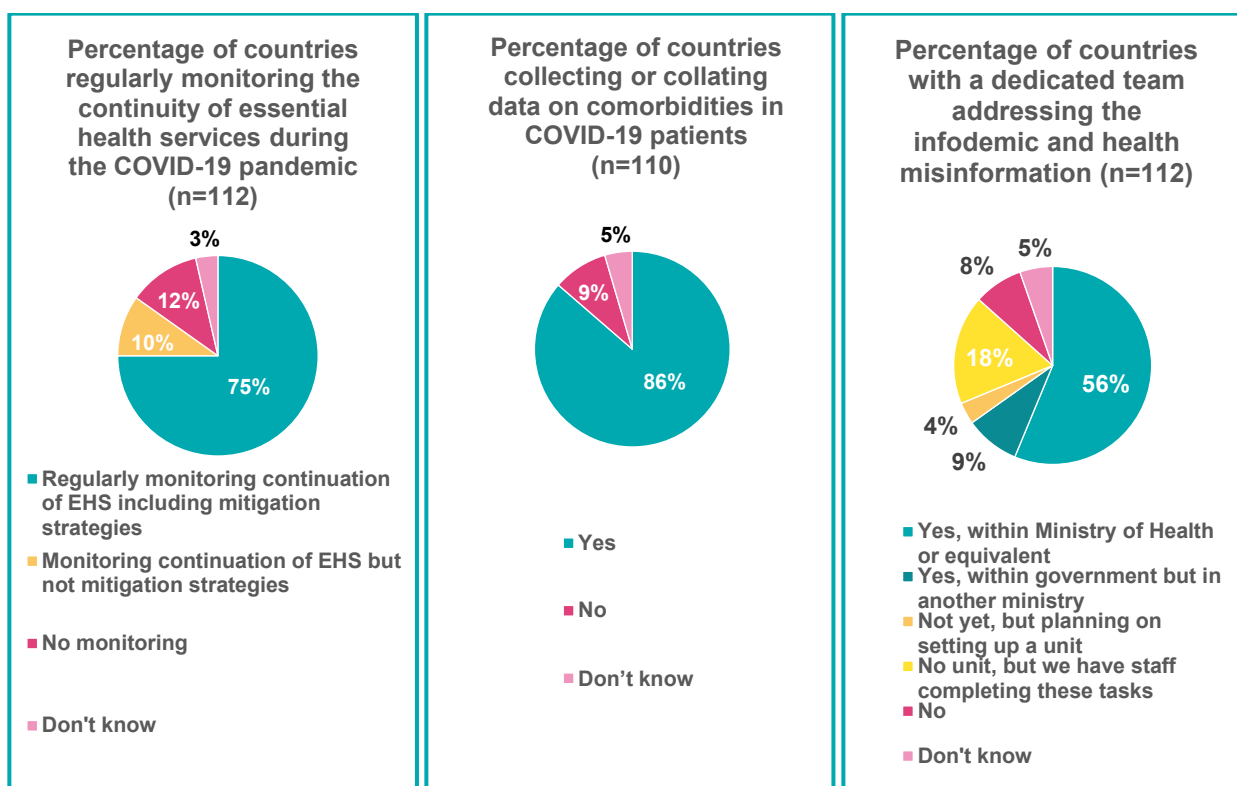
Information tracking

Tracking information related to essential health services during the rapidly changing course of the COVID-19 pandemic is essential to better understand the extent of disruptions and inform immediate response, planning and investment.

In the survey, 95 (85%) countries reported that they are regularly monitoring the continuity of essential health services during the COVID-19 pandemic, 84 (75%) of which are also monitoring implementation of strategies to mitigate service disruptions. To better understand evolving health needs of populations, 95 (86%) countries are also collecting and collating information on comorbidities in people living with COVID-19.

To better understand and respond to the infodemic and misinformation, 73 (65%) countries have also designated a dedicated team. These teams perform critical functions such as analysing and monitoring misinformation and how it affects acceptance of public health measures and health seeking behaviours and analysing and proposing evidence-based interventions to counter misinformation at national, subnational community and individual levels (see Figure 31, below).

Figure 31: Tracking continuity of essential health services during the COVID-19 pandemic



Tracking the global situation: Comparison of Round 1 and Round 2 survey findings

Results from the second pulse survey on continuity of essential health services were compared to findings from the first round. Round 1 data are sourced from: [Pulse survey on continuity of essential health services during the COVID-19 pandemic](#) (1) (May-September 2020); [Rapid assessment on the impact of the COVID-19 pandemic on noncommunicable disease resources and services](#) (2) (May 2020); and [Rapid assessment on the impact of COVID-19 on mental, neurological and substance use services](#) (3) (June-August 2020).

Two types of comparisons were completed to assess changes between the first (2020) and second (2021) survey rounds:

1. The first type of analysis compares global findings from all countries that participated in **either round 1 or round 2** of the survey.
2. The second type of analysis compares findings from the subset of countries that responded to **both rounds 1 and round 2** of the survey.

Changes in the extent of disruptions to specific tracer services were possible for the following 35 services, which were included in both survey rounds:

- Emergency, critical and operative care services: 24-hour emergency room/unit services; urgent blood transfusion services; inpatient critical care services; and emergency surgery;
- RMNCAH and nutrition services: family planning and contraception; antenatal care; facility-based births; sick child services; and management of malnutrition;
- Immunization services: facility-based routine immunization; and outreach routine immunization;
- Communicable disease services: Outbreak detection and control (non-COVID-19); continuation of established antiretroviral treatment; malaria diagnosis and treatment; ITN malaria prevention campaigns; IRS malaria prevention campaigns; and SMC malaria prevention campaigns;
- NCD services: cancer diagnosis and treatment; hypertension management; diabetes management; and asthma services;
- MNS disorder services: MNS emergency services; counselling for MNS disorders; medicines for MNS disorders; services for children and adolescents; services for older adults; school mental health programmes; suicide prevention programmes; overdose prevention programmes; and critical harm reduction services; and
- Rehabilitative and palliative care services: rehabilitation services; palliative services.

Tracking overall service disruptions

Overall, since 2020, the percentage of countries reporting disruptions to health services due to the COVID-19 pandemic has not changed substantially. The first type of comparison on countries participating in either survey round demonstrates that 89% of 135 countries are still reporting at least some level of disruption to services, only slightly down from the 95% of 187 countries reporting some level of disruption in 2020. Within countries though, decreases are observed in the extent to which services are disrupted. Figure 32 demonstrates a decrease in the average percentage of disrupted services per country from 50% of the 35 tracer services in the 2020 survey to 36% of those same services in the 2021 survey. The breakdown of countries demonstrates that 51% of countries were reporting that more than half of services were disrupted in 2020, and only 29% of countries are reporting disruptions to more than half of their services in 2021.

The second type of comparison on the same subset of 125 countries that participated in both survey rounds demonstrates a similar trend. It suggests that 89% of 125 countries are still reporting at least one service disruption, only slightly down from the 96% of 125 countries reporting this in 2020. The average percentage of service disruptions in country has decreased from 54% to 37% (see Figure 33, below). Fewer countries are reporting complete disruptions across all services. The breakdown of countries that participated in both surveys shows that in 2021, 31% of countries are reporting disruption to more than half of the 35 tracer services, a decrease from 2020 when 58% of countries were reporting this level of disruption.

Figure 32: Round 1 vs Round 2 comparison of countries participating in either survey round: Percentage of 35 tracer services disrupted per country

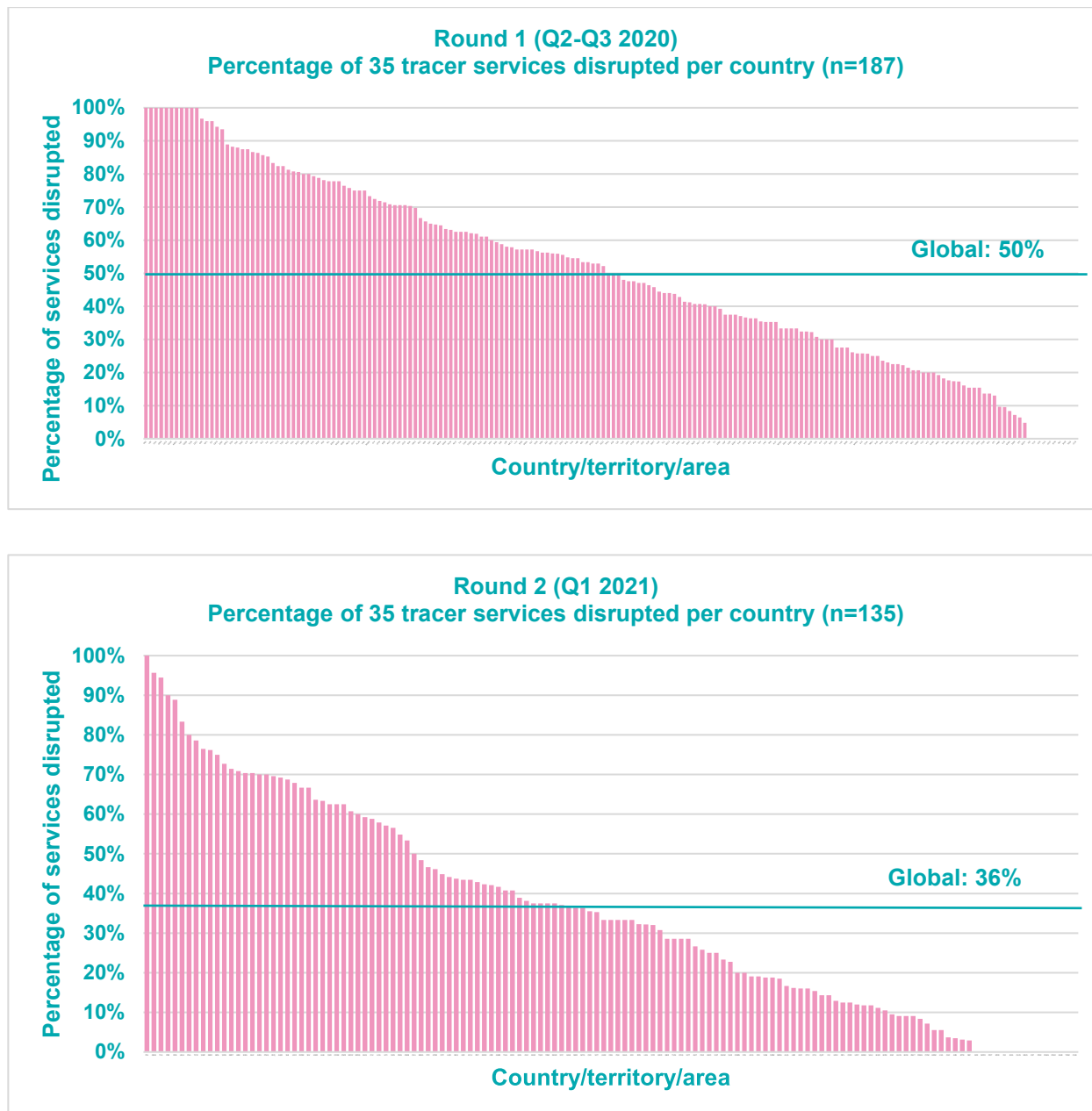
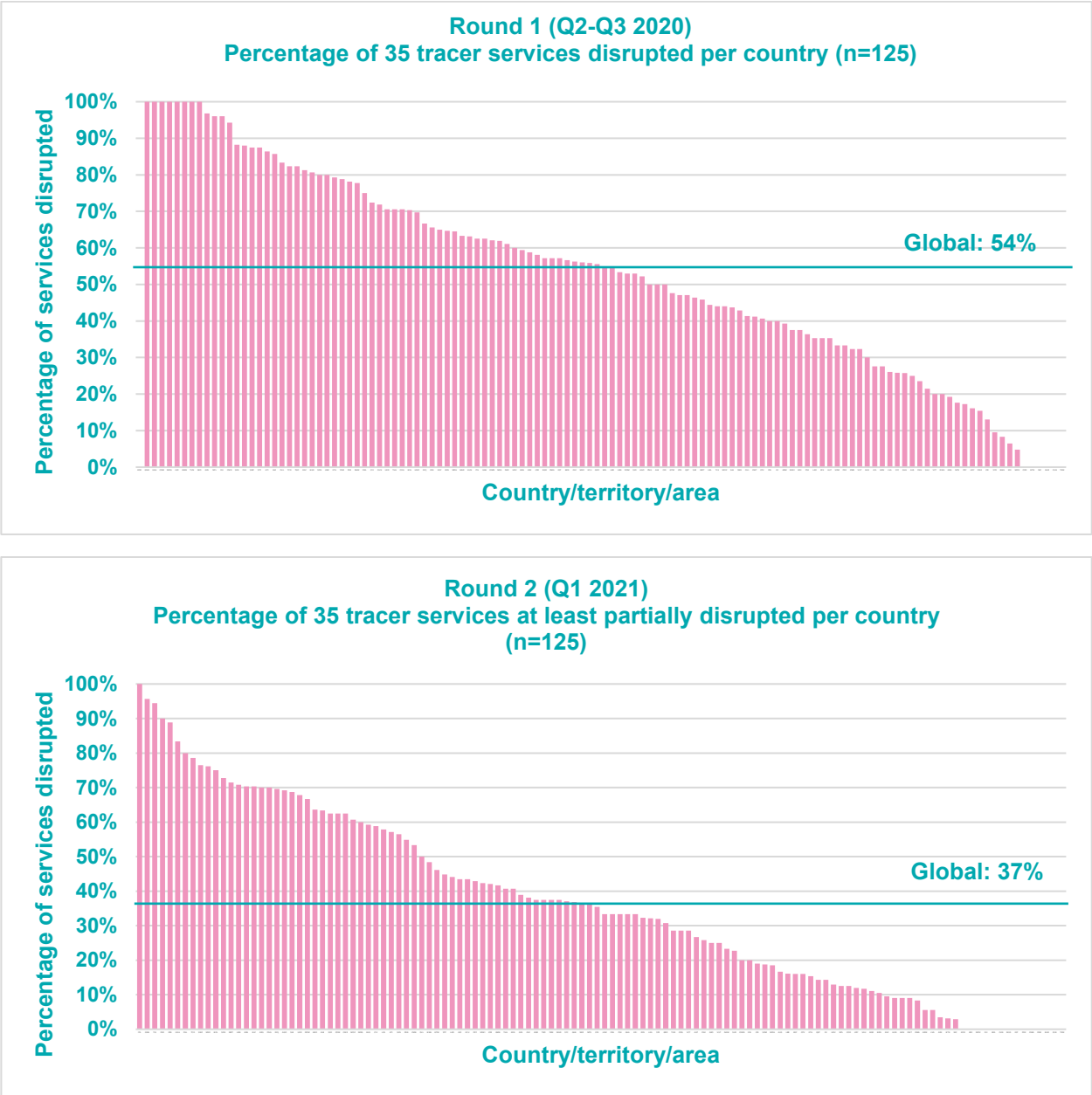


Figure 33: Round 1 vs Round 2 comparison of countries participating in both survey rounds:
Percentage of 35 tracer services disrupted per country



Tracking disruptions to tracer services

Overall, fewer countries are reporting disruptions across all tracer service groups compared to 2020 (see Figures 34-35, below). In both types of comparisons (on countries participating in either survey round and countries participating in both survey rounds), the largest decreases in percentage of countries reporting service disruptions are seen in immunization, rehabilitative and palliative care service

Figure 34: Round 1 vs. Round 2 comparison of countries participating in either survey round: Service disruptions by tracer service area

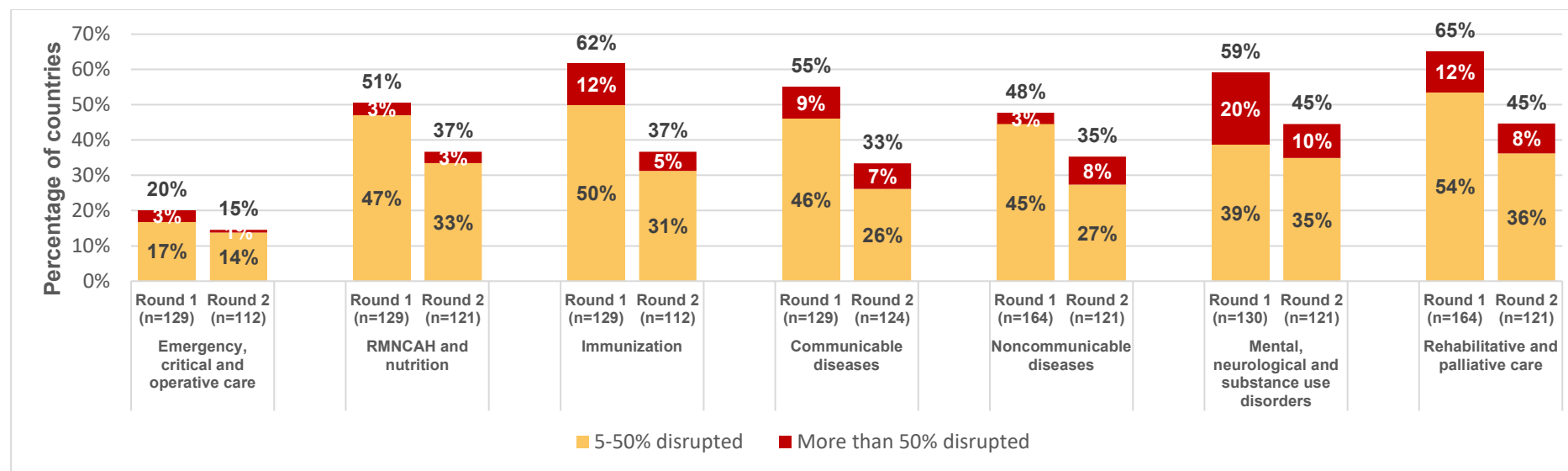
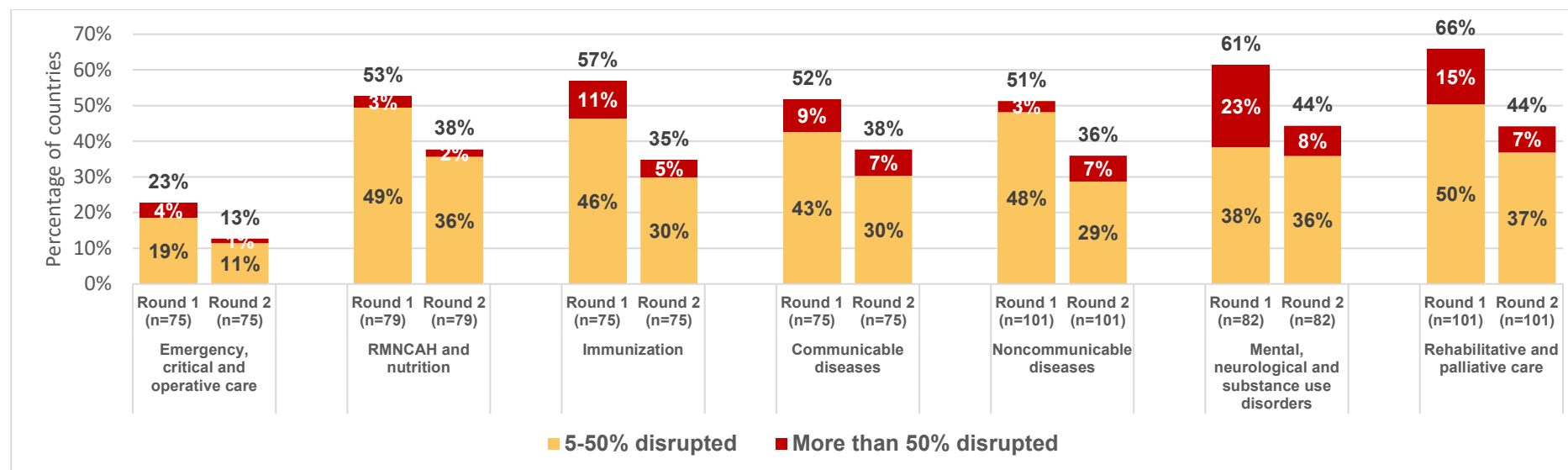


Figure 35: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Service disruptions by tracer service area



Analyses on the average percentage of tracer services disrupted in both survey rounds were also completed on countries that participated in either survey round (see Figure 36, below) as well as on the subset of countries that participated in both survey rounds (see Figure 37, below). Interpretation of findings may be limited due to the lack of participation by many countries with high transmission in the 2021 survey. Such regional comparisons were not possible due to the varied response rates across regions.

Figure 36: Round 1 vs. Round 2 comparison of countries participating in either survey round: Average percentage of tracer services disrupted by income group

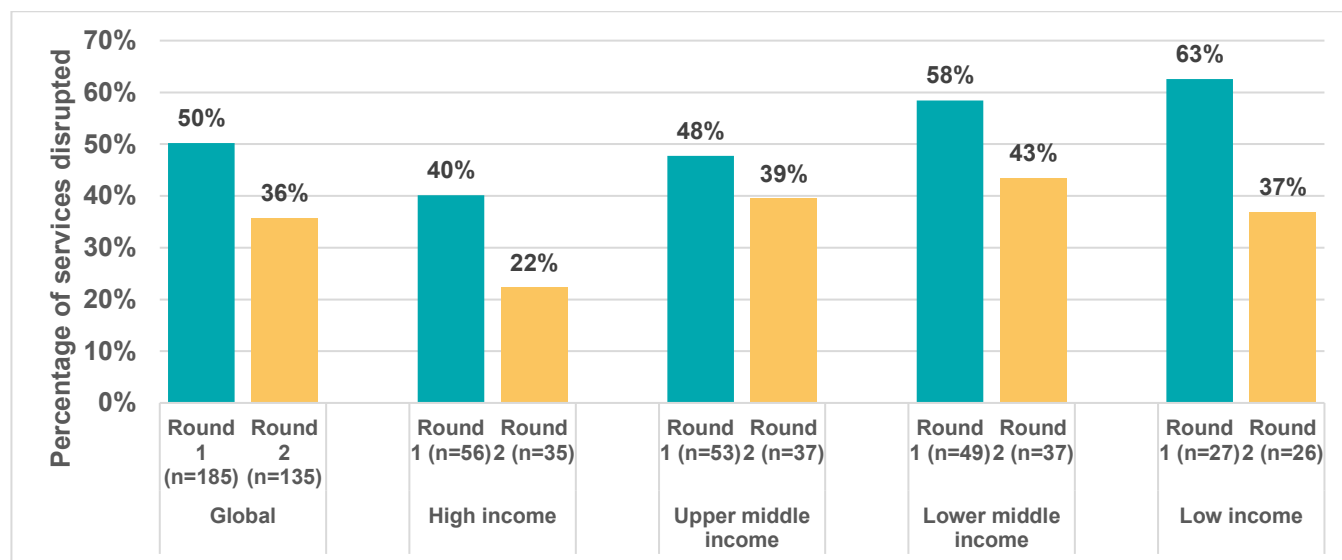
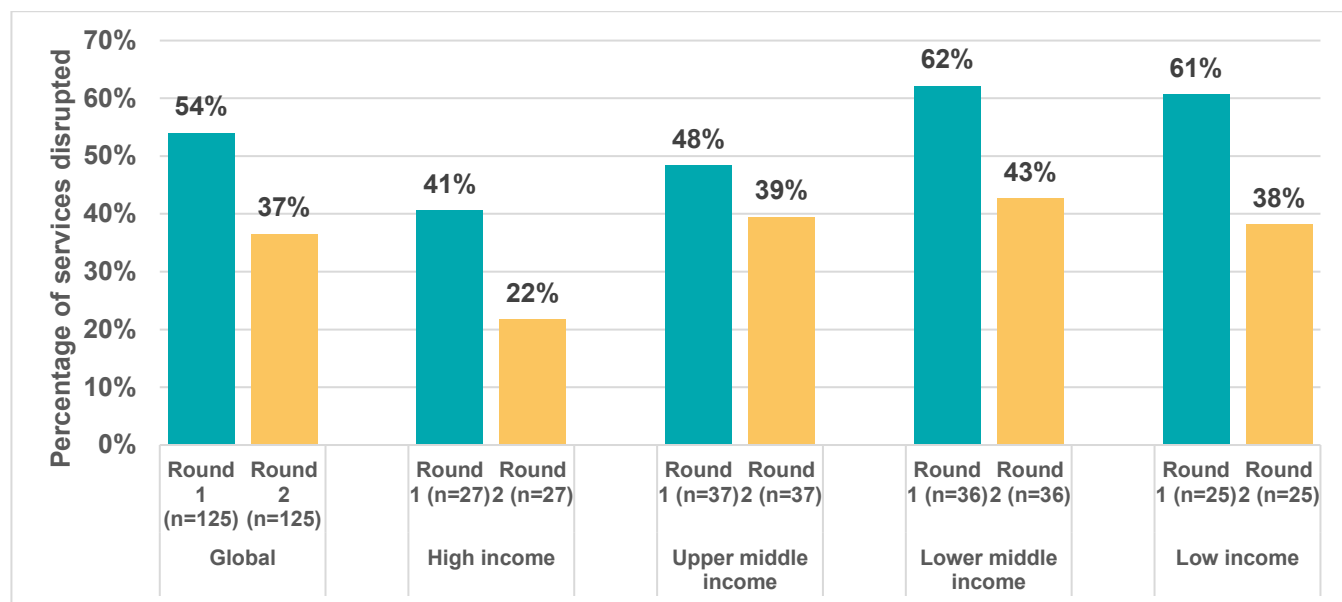


Figure 37: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Average percentage of tracer services disrupted by income group



Tracking disruptions to emergency, critical and operative care services

Overall, slightly fewer countries reported disruptions to emergency and critical care tracer services, excluding emergency surgery, in Round 2.

Figure 38 demonstrates that when comparing service disruptions in countries that participated in either survey round shows that:

- The percentage of countries reporting disruptions to 24-hour emergency room/unit services decreased from 20% (of 127 countries) in 2020 to 12% (of 91 countries) in 2021.
- The percentage of countries reporting disruptions to urgent blood transfusion services decreased from 21% (of 126 countries) in 2020 to 9% (of 92 countries) in 2021.
- The percentage of countries reporting disruptions to inpatient critical care services decreased from 23% (of 119 countries) in 2020 to 19% (of 94 countries) in 2021.
- The percentage of countries reporting disruptions to emergency surgery increased from 17% (of 125 countries) in 2020 to 18% (of 93 countries) in 2021.

A comparison of service disruptions in the subset of 74 countries that participated in both survey rounds (see Figure 39, below) shows similar trends:

- The percentage of countries reporting disruptions to 24-hour emergency room/unit services decreased from 22% (of 74 countries) in 2020 to 7% (of 60 countries) in 2021.
- The percentage of countries reporting disruptions to urgent blood transfusion services decreased from 26% (of 74 countries) in 2020 to 6% (of 62 countries) in 2021.
- The percentage of countries reporting disruptions to inpatient critical care services decreased from 24% (of 70 countries) in 2020 to 18% (of 60 countries) in 2021.
- The percentage of countries reporting disruptions to emergency surgery did not change. 19% of 72 countries and 62 countries reported disruptions in 2020 and 2021 respectively.

Figure 38: Round 1 vs. Round 2 comparison of countries participating in either survey round: Disruptions in emergency, critical and operative care services

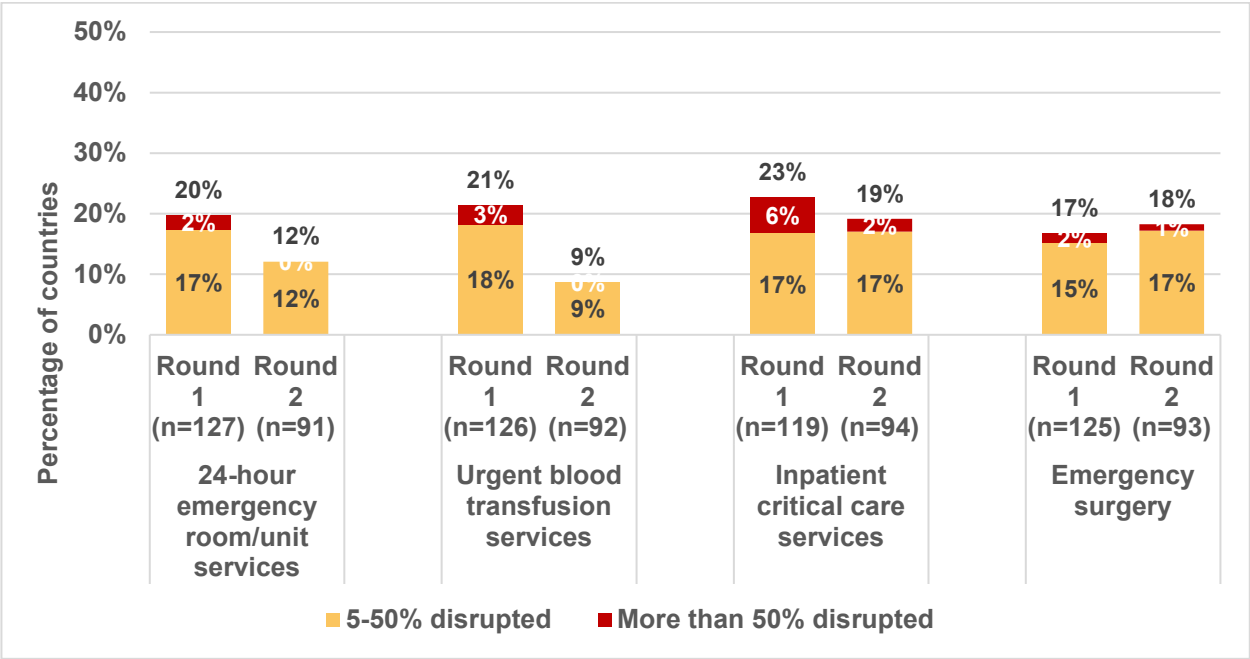
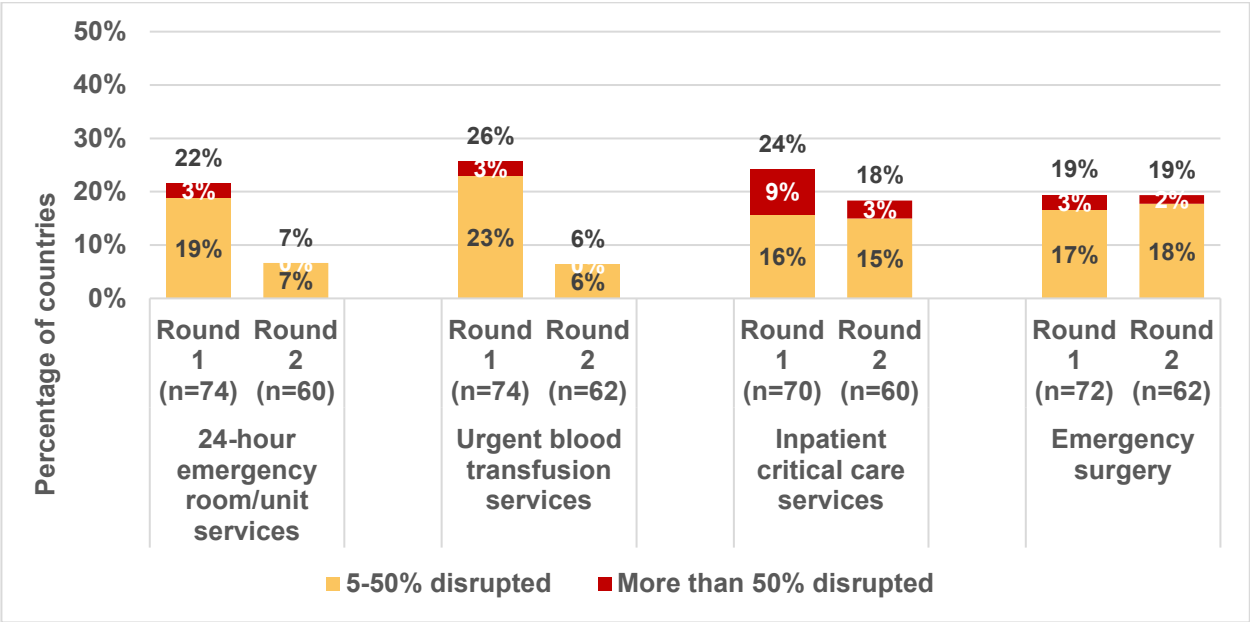


Figure 39: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Disruptions in emergency, critical and operative care services



The number of countries may not match across both survey rounds because “not applicable” and “do not know” responses have been dropped from the analysis.

Tracking disruptions to reproductive, maternal, newborn, child and adolescent health and nutrition services

In Round 2, fewer countries reported disruptions across all five tracer RMNCAH and nutrition services: family planning and contraception; antenatal care; facility-based births; sick child services; and management of malnutrition. Both types of comparison showed the largest decrease in percentage of countries reporting disruptions to family planning and contraception services.

The first comparison on countries participating in either survey round (see Figure 40, below) demonstrates that:

- The percentage of countries reporting disruptions to family planning and contraception services decreased from 66% (of 122 countries) in 2020 to 44% (of 104 countries) in 2021.
- The percentage of countries reporting disruptions to antenatal care decreased from 54% (of 127 countries) in 2020 to 39% (of 110 countries) in 2021.
- The percentage of countries reporting disruptions to facility-based births decreased from 31% (of 124 countries) in 2020 to 25% (of 104 countries) in 2021.
- The percentage of countries reporting disruptions to sick child services decreased from 52% (of 126 countries) in 2020 to 34% (of 101 countries) in 2021.
- The percentage of countries reporting disruptions to services for the management of malnutrition decreased from 50% (of 107 countries) in 2020 to 41% (of 92 countries) in 2021.

The second comparison on the countries that participated in both survey rounds shows similar trends (see Figure 41, below):

- The percentage of countries reporting disruptions to family planning and contraception services decreased from 67% (of 75 countries) in 2020 to 45% (of 69 countries) in 2021.
- The percentage of countries reporting disruptions to antenatal care decreased from 56% (of 78 countries) in 2020 to 40% (of 72 countries) in 2021.
- The percentage of countries reporting disruptions to facility-based births decreased from 34% (of 77 countries) in 2020 to 25% (of 68 countries) in 2021.
- The percentage of countries reporting disruptions to sick child services decreased from 53% (of 79 countries) in 2020 to 36% (of 69 countries) in 2021.
- The percentage of countries reporting disruptions to services for the management of malnutrition decreased from 53% (of 72 countries) in 2020 to 42% (of 64 countries) in 2021.

As noted above though, further information is needed to understand the reasons for the change in disruptions to particularly to services for sick children, and whether it is related to true disruptions or decreased spread of common childhood illnesses as an indirect effect of COVID-19 prevention measures.

Figure 40: Round 1 vs. Round 2 comparison of countries participating in either survey round: Disruptions in reproductive, maternal, newborn, child and adolescent health and nutrition and nutrition services

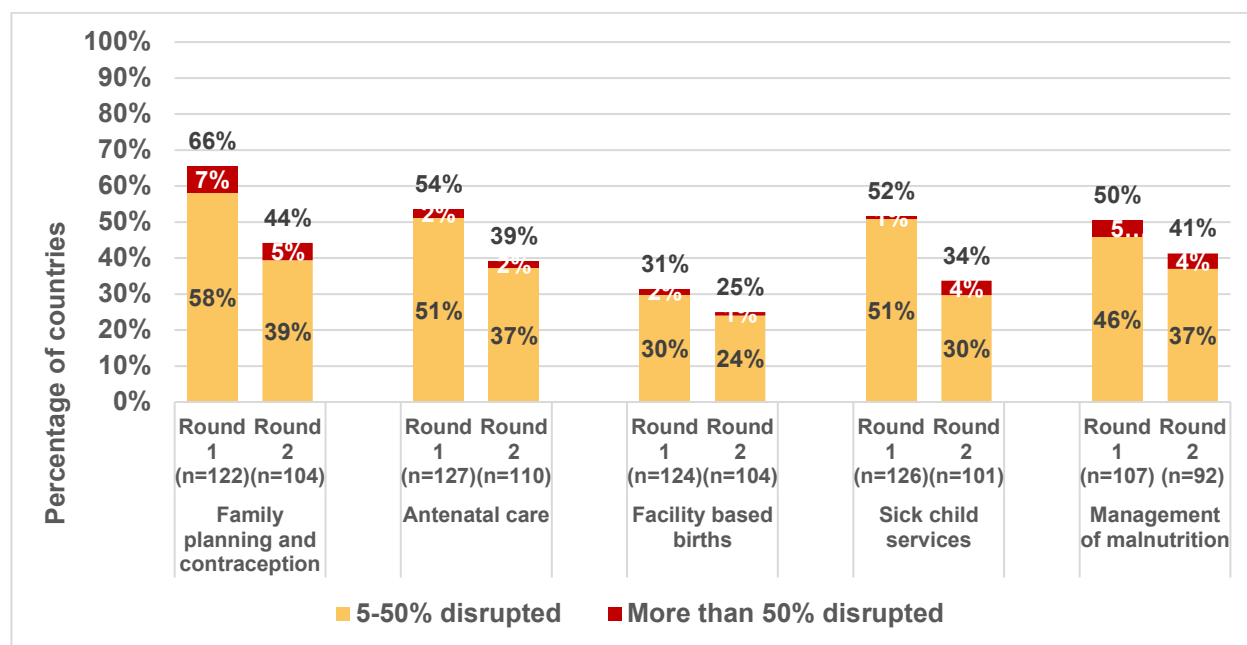
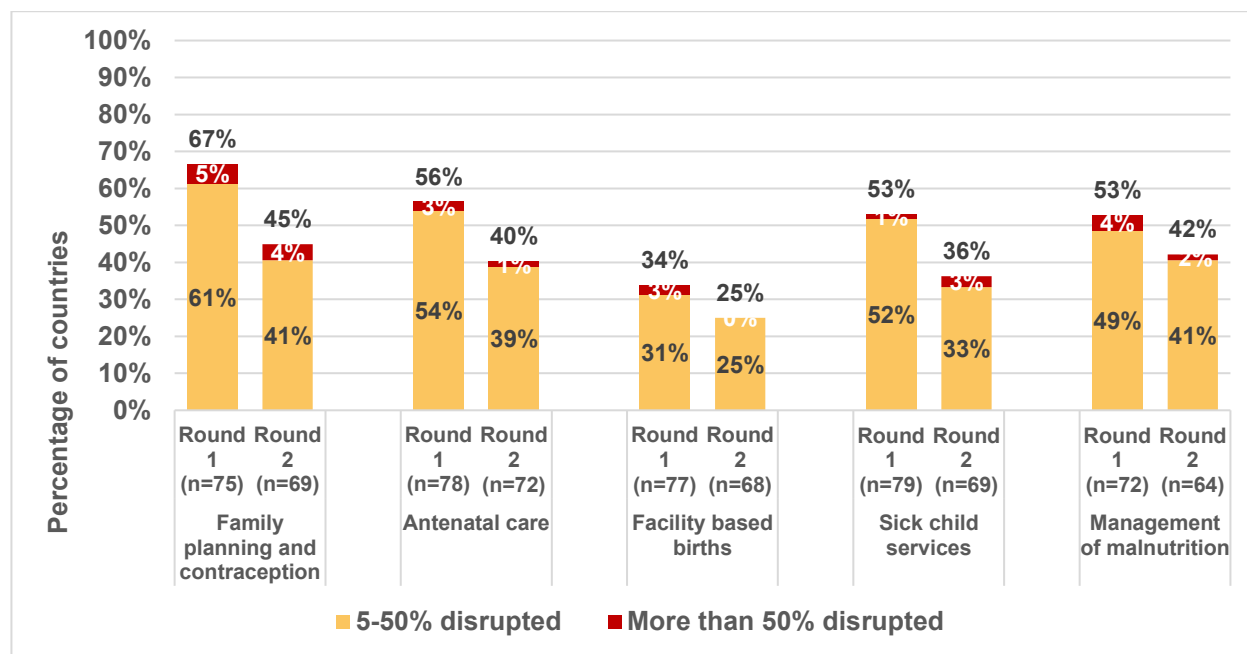


Figure 41: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Disruptions in reproductive, maternal, newborn, child and adolescent health and nutrition and nutrition services



The number of countries may not match across both survey rounds because “not applicable” and “do not know” responses have been dropped from the analysis.

Tracking disruptions to immunization services

The comparison between the first and second survey rounds on countries participating in either round (see Figure 42, below) showed:

- The percentage of countries reporting disruptions to facility-based routine immunization services decreased from 57% (of 129 countries) in 2020 to 34% (of 103 countries) in 2021.
- The percentage of countries reporting disruptions to routine outreach immunization services decreased from 67% (of 114 countries) in 2020 to 39% (of 89 countries) in 2021.

The comparison of countries participating in both survey rounds (see Figure 43, below) showed similar decreases:

- The percentage of countries reporting disruptions to facility-based routine immunization services decreased from 51% (of 72 countries) in 2020 to 33% (of 66 countries) in 2021.
- The percentage of countries reporting disruptions to routine outreach immunization services decreased from 63% (of 64 countries) in 2020 to 36% (of 55 countries) in 2021.

Despite decreases, more than one-third of countries are still reporting disruptions to routine facility-based and outreach immunization services.

Figure 42: Round 1 vs. Round 2 comparison of countries participating in either survey round: Disruptions in immunization services

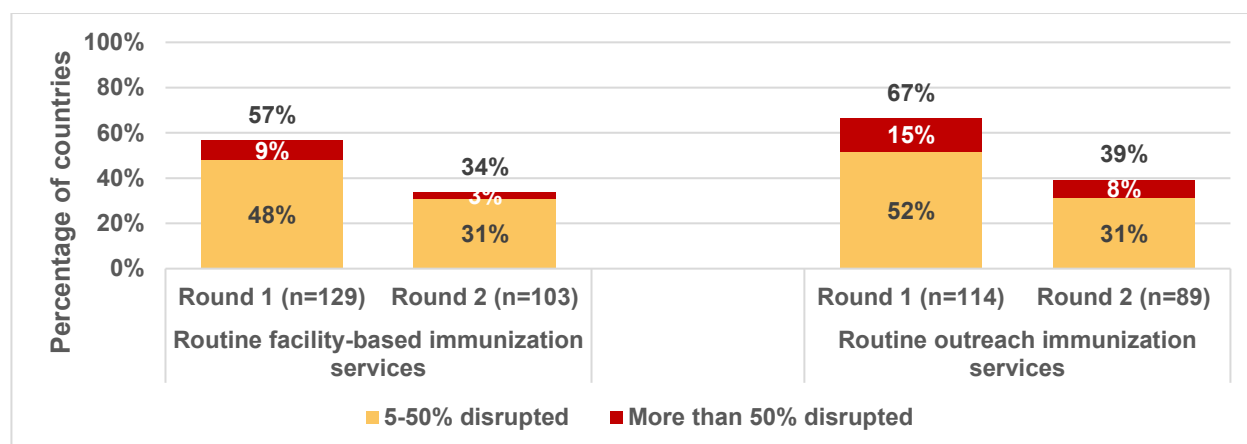
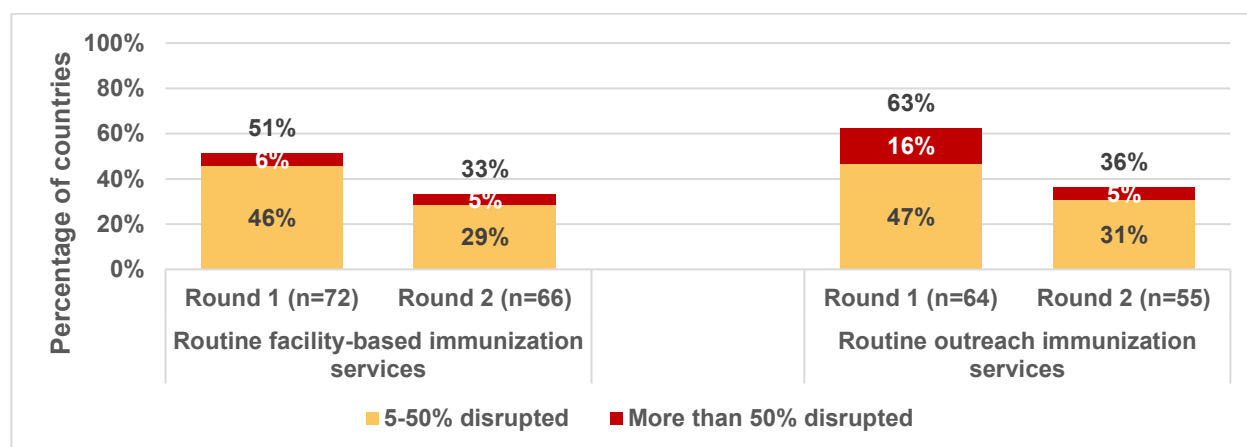


Figure 43: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Disruptions in immunization services



The number of countries may not match across both survey rounds because “not applicable” and “do not know” responses have been dropped from the analysis.

Tracking disruptions to noncommunicable disease services

Some decreases have been observed in countries reporting disruptions to NCD services since 2020, although the progress is not as substantial compared to decreases reported across some of the other tracer service areas.

The comparison on countries participating in either survey round (see Figure 44, below) demonstrates that:

- The percentage of countries reporting disruptions to cancer diagnosis and treatment services decreased from 44% (of 153 countries) in 2020 to 32% (of 90 countries) in 2021.
- The percentage of countries reporting disruptions to hypertension management services decreased from 55% (of 156 countries) in 2020 to 45% (of 95 countries) in 2021.
- The percentage of countries reporting disruptions to diabetes management services decreased from 51% (of 156 countries) in 2020 to 42% (of 97 countries) in 2021.
- The percentage of countries reporting disruptions to asthma services decreased from 52% (of 149 countries) in 2020 to 30% (of 87 countries) in 2021.
- The percentage of countries reporting disruptions to services for cardiovascular emergencies (including for myocardial infarction, stroke, and cardiac arrhythmias) decreased from 32% (of 156 countries) in 2020 to 20% (of 91 countries) in 2021.
- The percentage of countries reporting disruptions to urgent dental care decreased from 51% (of 147 countries) in 2020 to 42% (of 85 countries) in 2021.

The comparison on the subset of countries participating in both survey rounds (see Figure 45, below) demonstrates that:

- The percentage of countries reporting disruptions to cancer diagnosis and treatment services decreased from 49% (of 94 countries) in 2020 to 32% (of 74 countries) in 2021.
- The percentage of countries reporting disruptions to hypertension management services decreased from 58% (of 97 countries) in 2020 to 48% (of 81 countries) in 2021.
- The percentage of countries reporting disruptions to diabetes management services decreased from 55% (of 97 countries) in 2020 to 45% (of 82 countries) in 2021.
- The percentage of countries reporting disruptions to asthma services decreased from 57% (of 91 countries) in 2020 to 30% (of 74 countries) in 2021.
- The percentage of countries reporting disruptions to services for cardiovascular emergencies (including for myocardial infarction, stroke, and cardiac arrhythmias) decreased from 32% (of 96 countries) in 2020 to 20% (of 80 countries) in 2021.
- The percentage of countries reporting disruptions to urgent dental care decreased from 57% (of 90 countries) in 2020 to 40% (of 72 countries) in 2021.

Figure 44: Round 1 vs. Round 2 comparison of countries participating in either survey round: Disruptions in noncommunicable disease services

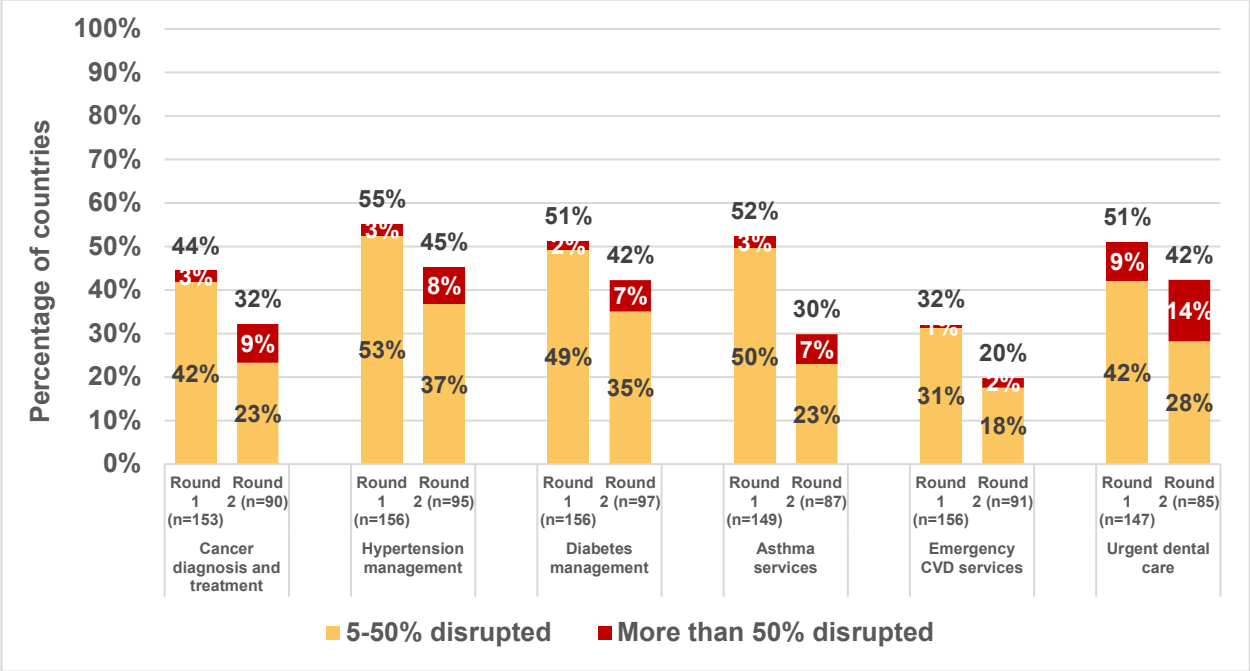
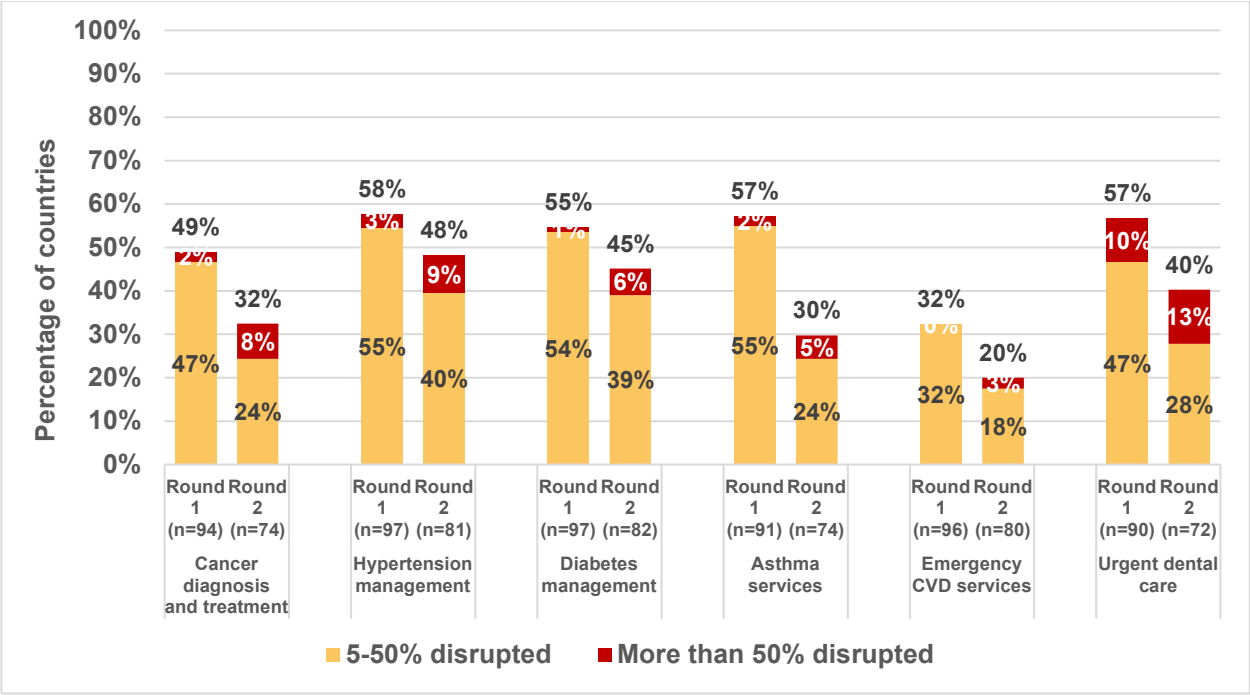


Figure 45: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Disruptions in noncommunicable disease services



The number of countries may not match across both survey rounds because “not applicable” and “do not know” responses have been dropped from the analysis.

Tracking disruptions to communicable disease services

Overall, fewer countries are reporting disruptions across most tracer services for communicable diseases compared to 2020, although decreases in disruptions to communicable diseases are not as substantial as those observed for other tracer services.

Figure 46 compares disruptions to communicable disease services between the two survey rounds in countries participating in either survey round:

- The percentage of countries reporting disruptions to outbreak detection and control activities decreased from 41% (of 123 countries) in 2020 to 25% (of 91 countries) in 2021.
- The percentage of countries reporting disruptions to services for the continuation of antiretroviral (ARV) treatment for HIV decreased from 31% (of 120 countries) in 2020 to 17% (of 98 countries) in 2021.
- The percentage of countries reporting disruptions to malaria diagnosis and treatment decreased from 58% (of 64 countries) in 2020 to 39% (of 59 countries) in 2021.
- The percentage of countries reporting disruptions to malaria prevention campaigns have decreased substantially, from:
 - 69% (of 54 countries) in 2020 to 39% (of 49 countries) in 2021 to campaigns for insecticide treated net (ITN) distribution.
 - 67% (of 52 countries) in 2020 to 33% (of 43 countries) in 2021 to campaigns for indoor residual spraying (IRS).
 - 80% (of 20 countries) in 2020 to 30% (of 10 countries) in 2021 to seasonal malaria chemoprevention campaigns.
- The percentage of countries reporting disruptions to TB diagnosis and treatment increased from 40% (of 124 countries) in 2020 to 51% (of 98 countries) in 2021.

The analyses on countries that participated in both survey rounds (see Figure 47, below) show similar trends:

- The percentage of countries reporting disruptions to outbreak detection and control activities decreased from 36% (of 61 countries) in 2020 to 32% (of 57 countries) in 2021.
- The percentage of countries reporting disruptions to services for the continuation of antiretroviral (ARV) treatment for HIV decreased from 30% (of 61 countries) in 2020 to 16% (of 56 countries) in 2021.
- The percentage of countries reporting disruptions to malaria diagnosis and treatment decreased from 55% (of 40 countries) in 2020 to 46% (of 35 countries) in 2021.
- The percentage of countries reporting disruptions to malaria prevention campaigns have decreased from:
 - 60% (of 30 countries) in 2020 to 35% (of 31 countries) in 2021 to campaigns for insecticide treated net (ITN) distribution.
 - 57% (of 30 countries) in 2020 to 33% (of 27 countries) in 2021 to campaigns for indoor residual spraying (IRS).
 - 83% (of 6 countries) in 2020 to 50% (of 6 countries) in 2021 to seasonal malaria chemoprevention campaigns.
- The percentage of countries reporting disruptions to TB diagnosis and treatment increased from 41% (of 63 countries) in 2020 to 52% (of 60 countries) in 2021.

Of note, TB diagnosis and treatment is the only tracer service for which a moderate increase has been observed in countries reporting disruptions since 2020. Figures 46 and 47 also show that slightly more countries are reporting disruption levels of more than 50% for TB diagnosis and treatment in 2021. In 2020 no countries reported disruptions at this level.

Figure 46: Round 1 vs. Round 2 comparison of countries participating in either survey round: Disruptions in communicable disease services

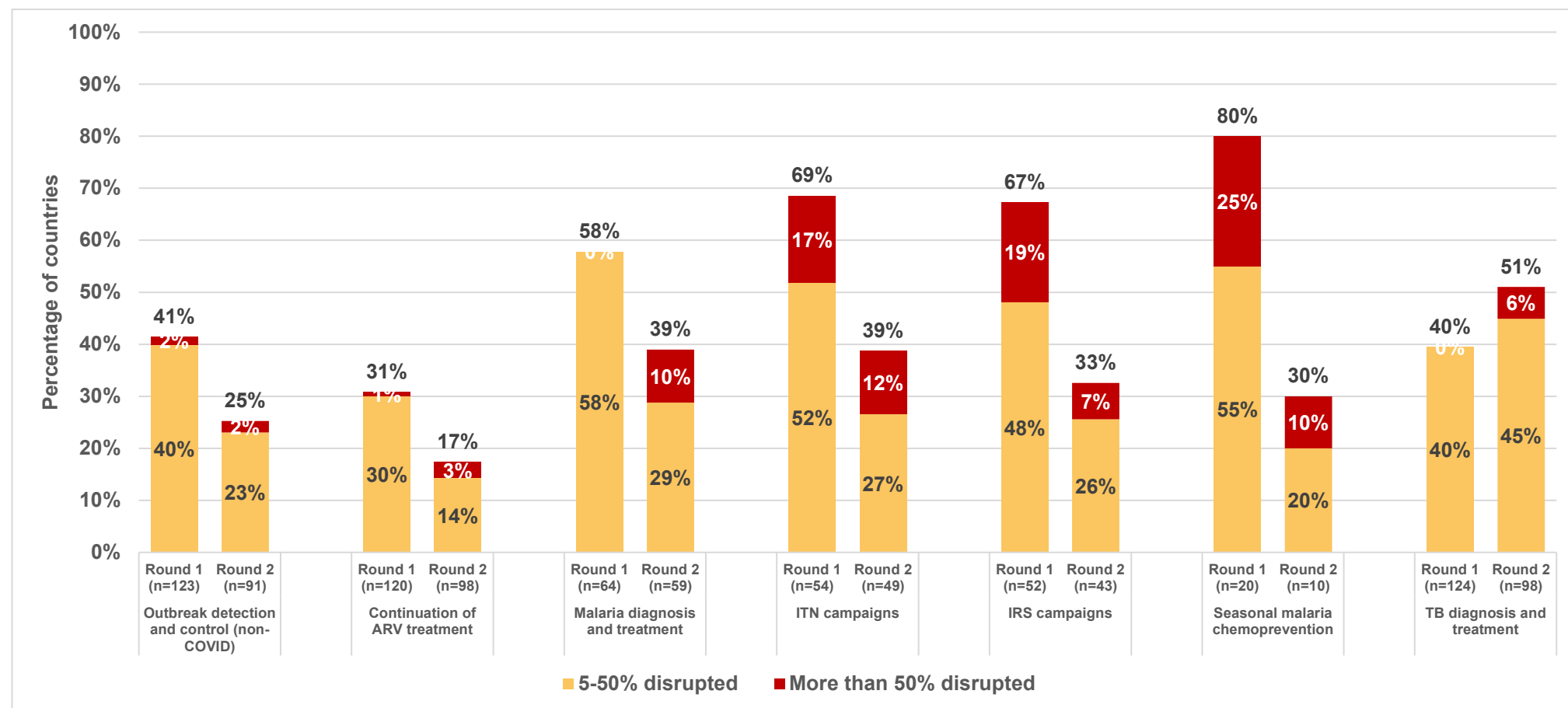
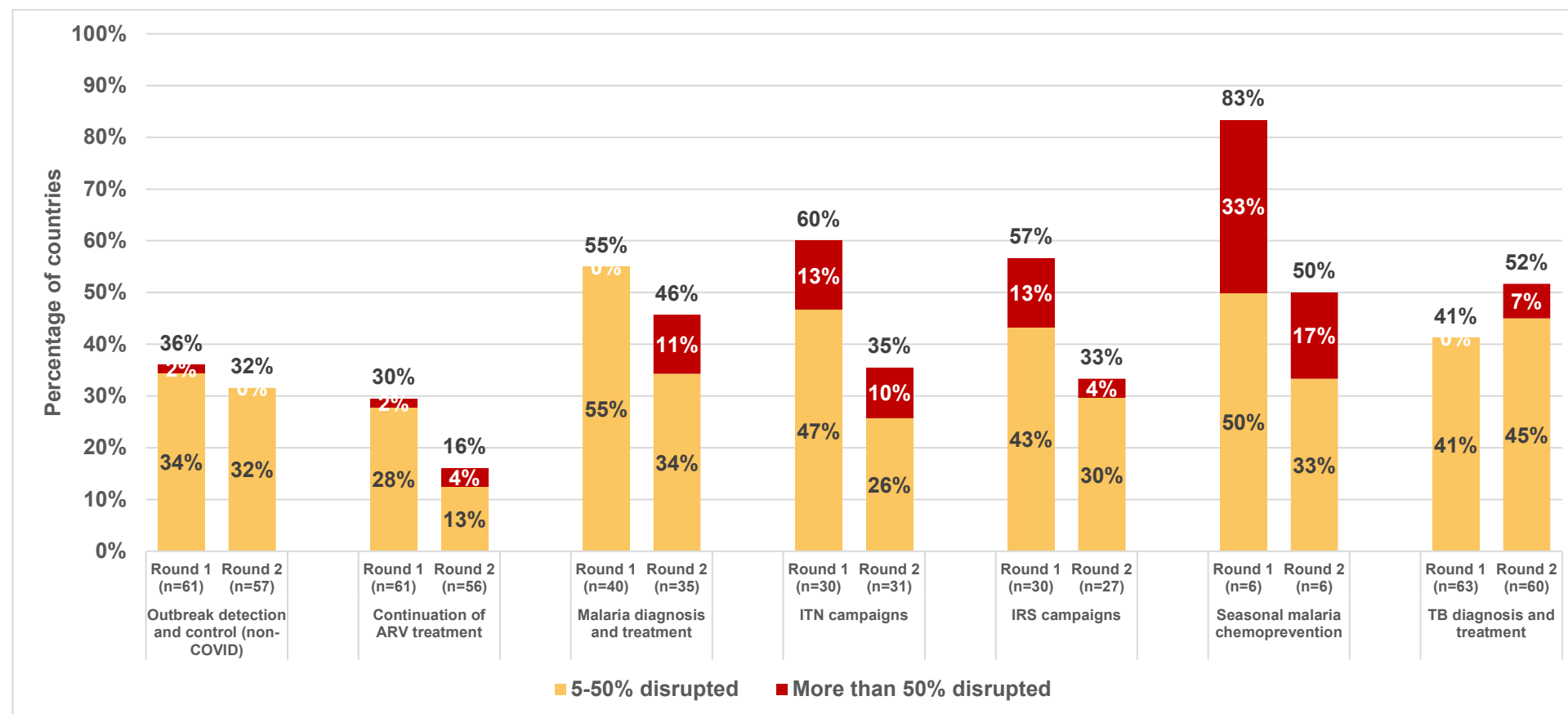


Figure 47: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Disruptions in communicable disease services



The number of countries may not match across both survey rounds because “not applicable” and “do not know” responses have been dropped from the analysis.

Tracking disruptions to services for mental, neurological, and substance use disorders

While disruptions are being reported in fewer countries across most MNS tracer services compared to quarters 2-3 of 2020, MNS services still remain among the most disrupted services. All such services remain disrupted in at least one-third of countries approximately.

The analyses on countries participating in either survey round (see Figure 48, below) show that:

- The percentage of countries reporting disruptions to management of emergency MNS manifestations (including status epilepticus, delirium, and severe substance withdrawal syndromes) increased slightly from 35% (of 124 countries) in 2020 to 39% (of 94 countries) in 2021.
- The percentage of countries reporting disruptions to psychotherapy, counselling, and psychosocial interventions for MNS disorders decreased from 67% (of 126 countries) in 2020 to 54% (of 95 countries) in 2021.
- The percentage of countries reporting disruptions to services to prescribe MNS medicines increased slightly from 30% (of 125 countries) in 2020 to 32% (of 91 countries) in 2021.
- The percentage of countries reporting disruptions to services for children and adolescents with mental health conditions or disabilities, including developmental disabilities, decreased from 72% (of 125 countries) in 2020 to 45% (of 86 countries) in 2021.
- The percentage of countries reporting disruptions to services for older adults with mental health conditions or disabilities, including dementia, decreased from 70% (of 120 countries) in 2020 to 48% (of 85 countries) in 2021.
- The percentage of countries reporting disruptions to school mental health programmes decreased from 78% (of 112 countries) in 2020 to 66% (of 53 countries) in 2021.
- The percentage of countries reporting disruptions to suicide prevention programmes decreased from 61% (of 104 countries) in 2020 to 44% (of 57 countries) in 2021.
- The percentage of countries reporting disruptions to overdose prevention and management programmes decreased from 53% (of 94 countries) in 2020 to 34% (of 44 countries) in 2021.
- The percentage of countries reporting disruptions to critical harm reduction services decreased from 65% (of 92 countries) in 2020 to 39% (of 44 countries) in 2021.

Analyses on countries participating in both survey rounds (see Figure 49, below) show that:

- The percentage of countries reporting disruptions to management of emergency MNS manifestations (including status epilepticus, delirium, and severe substance withdrawal syndromes) increased slightly from 38% (of 78 countries) in 2020 to 40% (of 62 countries) in 2021.
- The percentage of countries reporting disruptions to psychotherapy, counselling, and psychosocial interventions for MNS disorders decreased from 68% (of 79 countries) in 2020 to 52% (of 63 countries) in 2021.
- The percentage of countries reporting disruptions to services to prescribe MNS medicines decreased slightly from 33% (of 78 countries) in 2020 to 30% (of 61 countries) in 2021.
- The percentage of countries reporting disruptions to services for children and adolescents with mental health conditions or disabilities, including developmental disabilities, decreased from 77% (of 77 countries) in 2020 to 44% (of 59 countries) in 2021.
- The percentage of countries reporting disruptions to services for older adults with mental health conditions or disabilities, including dementia, decreased from 76% (of 74 countries) in 2020 to 48% (of 58 countries) in 2021.
- The percentage of countries reporting disruptions to school mental health programmes decreased from 81% (of 73 countries) in 2020 to 66% (of 38 countries) in 2021.
- The percentage of countries reporting disruptions to suicide prevention programmes decreased from 57% (of 68 countries) in 2020 to 48% (of 42 countries) in 2021.
- The percentage of countries reporting disruptions to overdose prevention and management programmes decreased from 54% (of 59 countries) in 2020 to 34% (of 32 countries) in 2021.

- The percentage of countries reporting disruptions to critical harm reduction services decreased from 67% (of 58 countries) in 2020 to 37% (of 30 countries) in 2021.

Across both analyses, the most notable decreases in percentage of countries reporting disruptions are to services for vulnerable populations, including children, adolescents, and older adults with mental health conditions or disabilities. Still, nearly half of reporting countries are reporting disruptions to these services.

Figure 48: Round 1 vs. Round 2 comparison of countries participating in either survey round: Disruptions in services for mental, neurological and substance use disorders

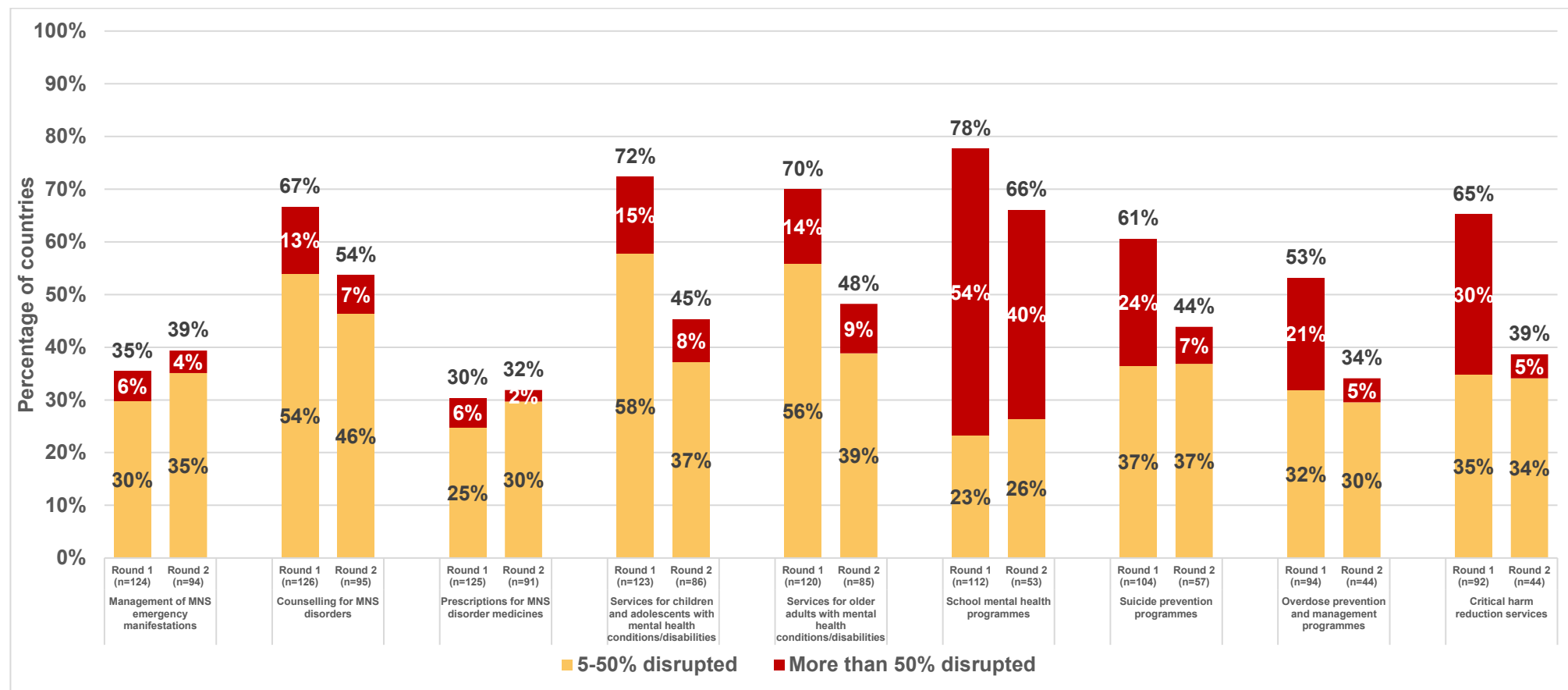
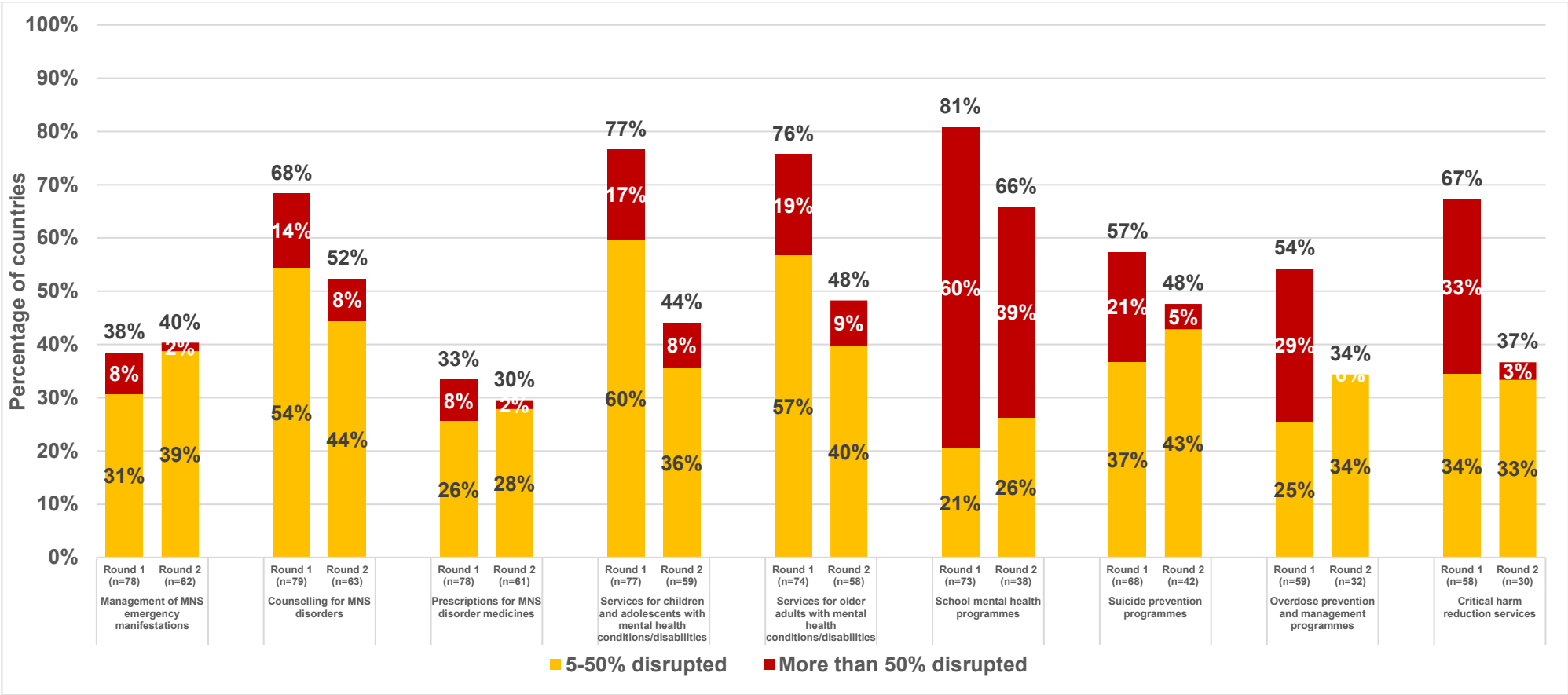


Figure 49: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Disruptions in services for mental, neurological and substance use disorders



The number of countries may not match across both survey rounds because “not applicable” and “do not know” responses have been dropped from the analysis.

Tracking disruptions to rehabilitation and palliative care services

During quarters 2-3 of 2020, rehabilitation and palliative care services were among the most disrupted services.

Figure 50 demonstrates the change in percentage of countries participating in either survey round that reported disruptions to rehabilitative and palliative care services:

- The percentage of countries reporting disruptions to rehabilitative services decreased from 73% (of 139 countries) in 2020 to 53% (of 89 countries) in 2021.
- The percentage of countries reporting disruptions to palliative care decreased from 57% (of 139 countries) in 2020 to 36% (of 74 countries) in 2021.

Figure 51 shows similar decreases across the countries that participated in both survey rounds:

- The percentage of countries reporting disruptions to rehabilitative services decreased from 71% (of 58 countries) in 2020 to 55% (of 60 countries) in 2021.
- The percentage of countries reporting disruptions to palliative care decreased from 61% (of 59 countries) in 2020 to 33% (of 48 countries) in 2021.

While substantial decreases have been observed in the percentage of countries reporting disruptions to these services, disruptions still remain. Rehabilitation services are still disrupted in more than half of countries, and palliative care services are still disrupted in at least one-third of countries.

Figure 50: Round 1 vs. Round 2 comparison of countries participating in either survey round: Disruptions in rehabilitative and palliative care

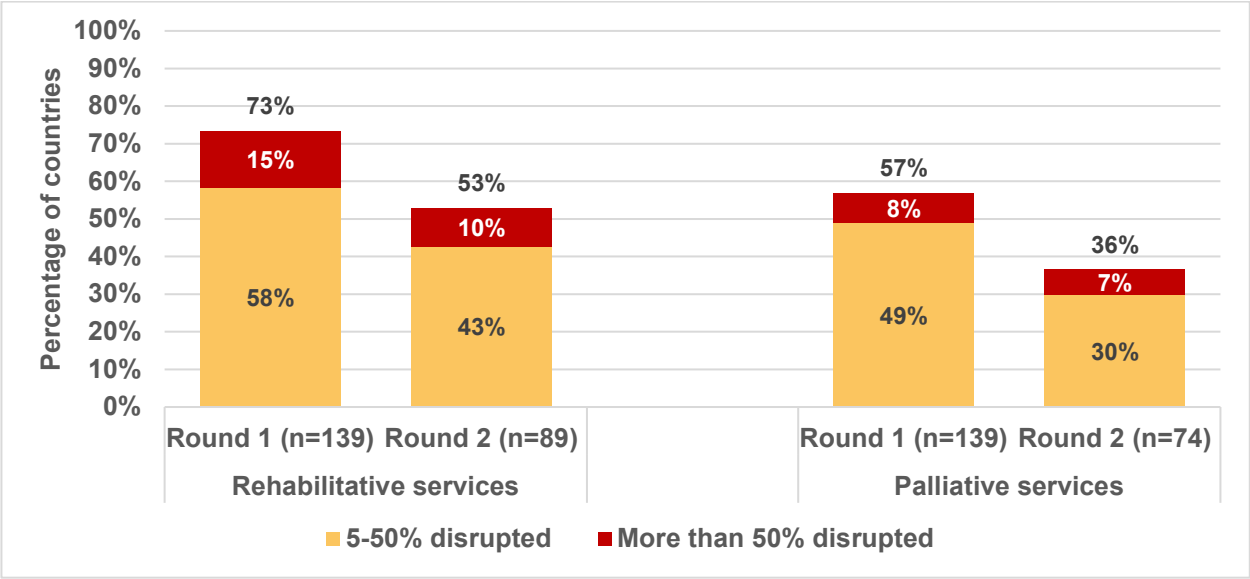
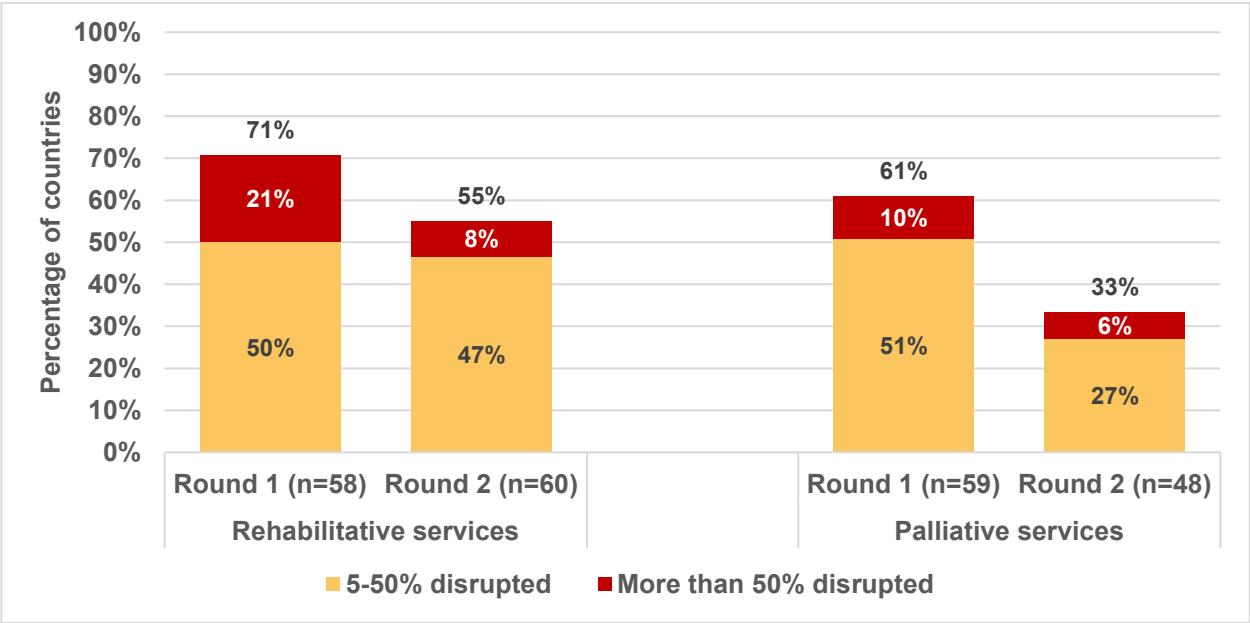


Figure 51: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Disruptions in rehabilitative and palliative care



The number of countries may not match across both survey rounds because “not applicable” and “do not know” responses have been dropped from the analysis.

Tracking reported reasons for service disruptions

In comparing the main causes for service disruptions reported in the first and second rounds of the pulse survey in countries participating in either survey round, staff availability, patients not presenting to outpatient care and cancellation of elective care in inpatient settings are still among the most frequently reported reasons for service disruptions (see Figure 52, below). Moreover, slightly more countries are reporting disruptions due to staff unavailability compared to 2020.

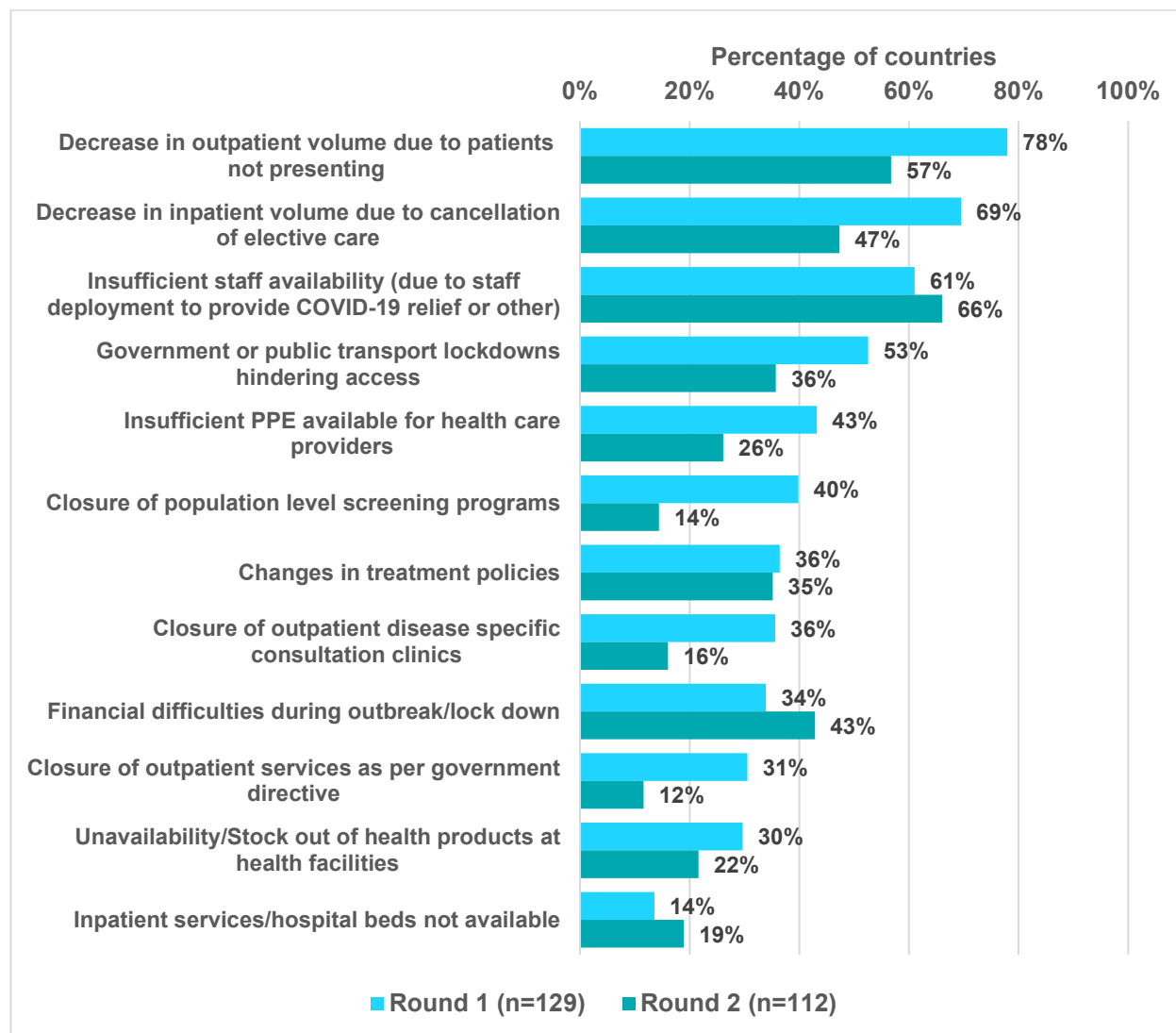
No substantial changes have been seen in the percentage of countries reporting changes in treatment policies as reasons for disruptions.

By contrast, fewer countries are reporting disruptions due to insufficient resources (including availability of personal protective equipment and health products) compared to what they reported in the first round of the survey.

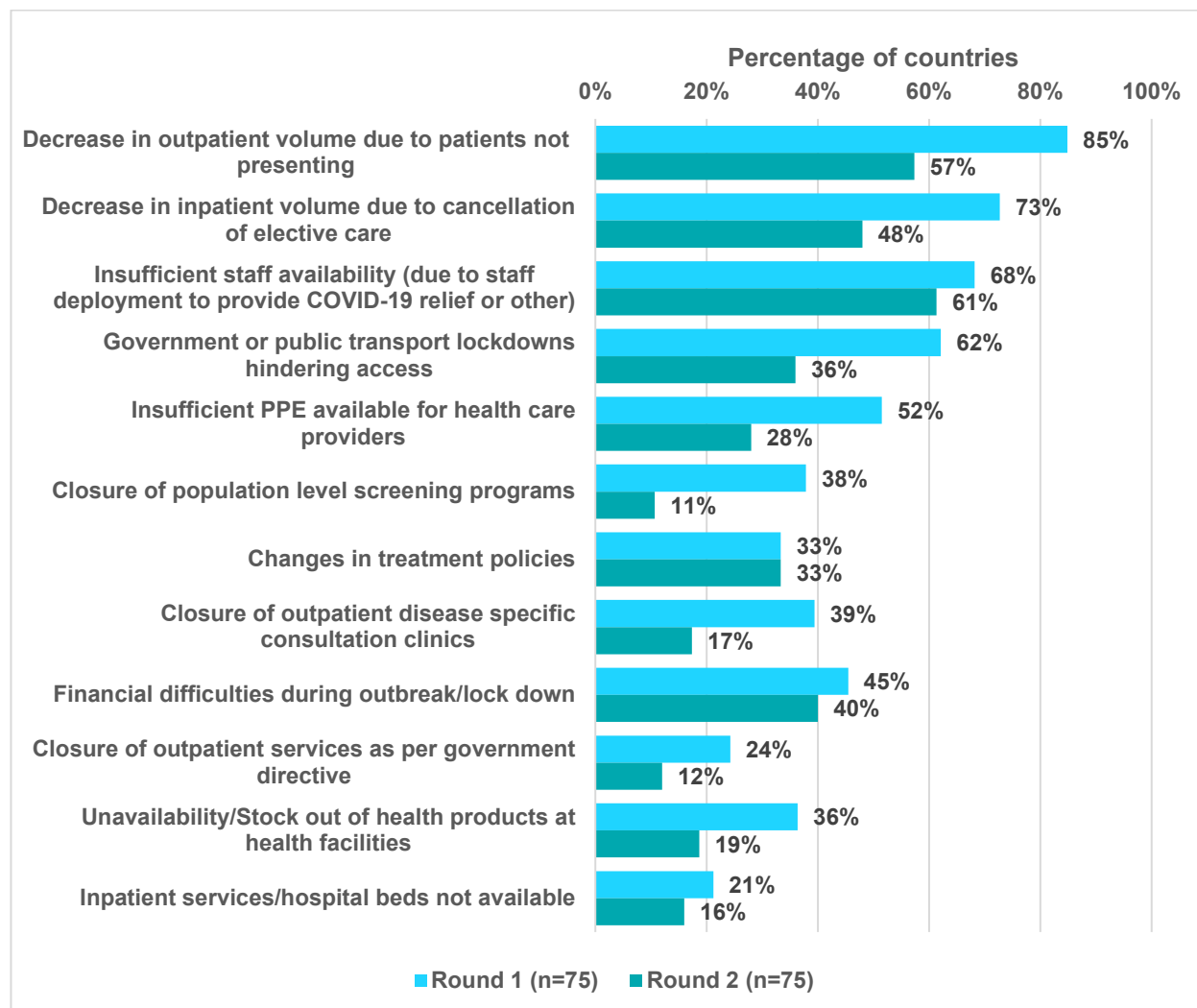
Similar results are found in the comparison of countries that participated in both pulse survey rounds (see Figure 53, below). Staff availability, patients not presenting to outpatient care and cancellation of elective care in inpatient settings remain the most frequently reported reasons for service disruptions, and slightly more countries are reporting disruptions due to staff unavailability in 2021.

In 2021, no change is seen in the percentage of countries reporting changes in treatment policies, and fewer countries are reporting disruptions due to availability of personal protective equipment and health products compared to 2020.

**Figure 52: Round 1 vs. Round 2 comparison of countries participating in either survey round:
Reasons for service disruptions**



**Figure 53: Round 1 vs. Round 2 comparison of countries participating in both survey rounds:
Reasons for service disruptions**



Tracking national policies, plans and mechanisms to support continuity of essential health services

Figure 54 captures changes in policies and mechanisms to support continuity of essential health services during the COVID-19 pandemic in countries that participated in either survey round. It demonstrates that compared to the first survey round, more countries have now defined core services to be maintained during the COVID-19 pandemic, a critical first step to ensuring continuity of care throughout all phases of the pandemic. By contrast, no substantial change has been seen in the percentage of countries that are allocating additional funds for maintaining essential health services.

The same analyses on the 75 countries that participated in both survey rounds show similar findings (see Figure 55, below). Compared to 2020, 17 (22%) more countries have now defined essential health services to be maintained during the pandemic in a national policy or plan. No substantial change is seen in the percentage of countries allocating additional funding for continuity of care during the pandemic.

Figure 54: Round 1 vs. Round 2 comparison of countries participating in either survey round: Countries with national policies and additional funding for maintaining essential health services

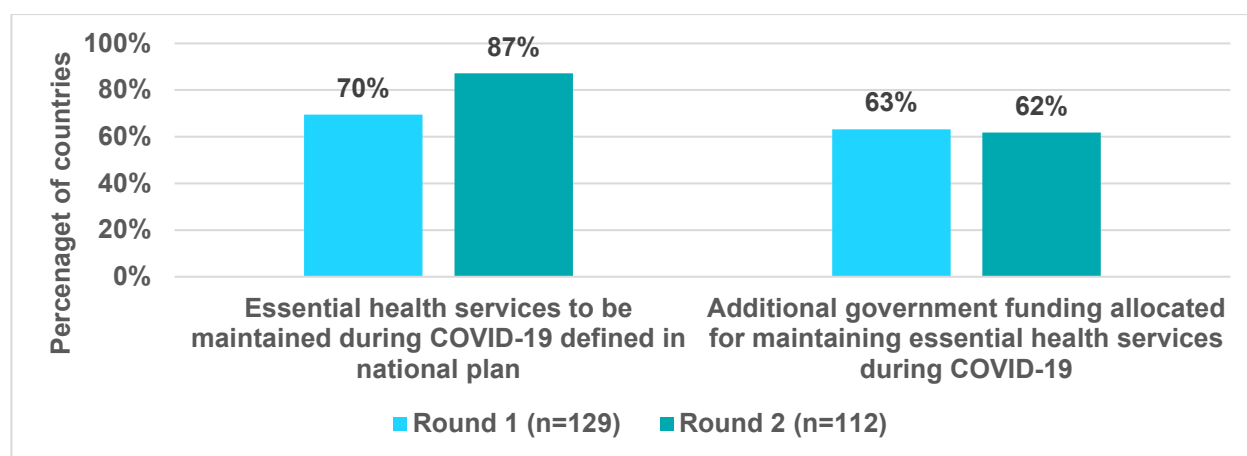
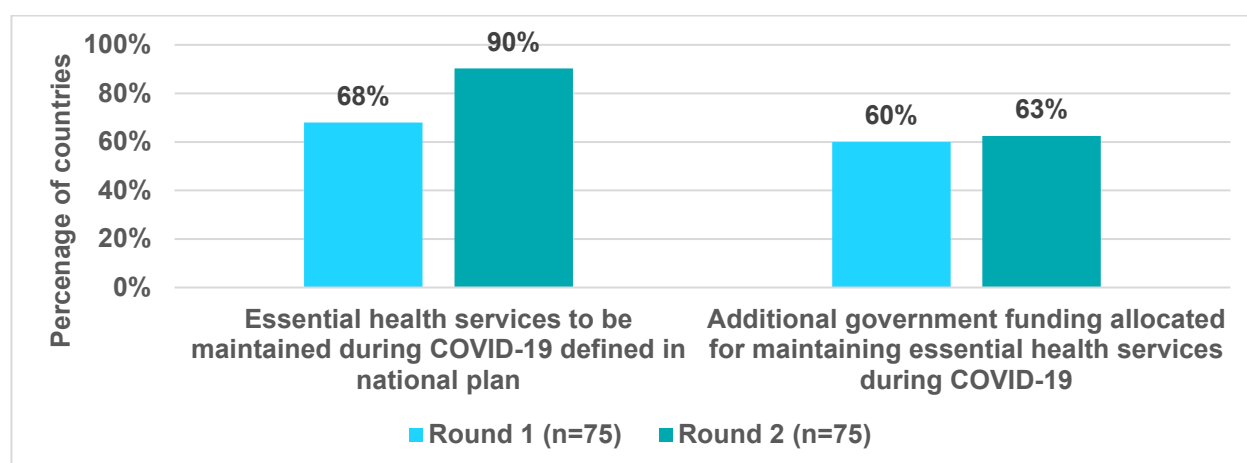


Figure 55: Round 1 vs. Round 2 comparison of countries participating in both survey rounds: Countries with national policies and additional funding for maintaining essential health services



Tracking strategic modifications to service delivery

Fewer countries are reporting intentional limiting or suspending of access most service delivery platforms compared to quarters 2-3 of 2020.

Analysing changes across countries that participated in either survey round (see Figure 56, below) show that:

- The percentage of countries that have limited or suspended outpatient services has decreased from 62% (of 129 countries) in 2020 to 38% (of 112 countries) in 2021.
- The percentage of countries that have limited or suspended community-based care has decreased from 57% (of 129 countries) in 2020 to 45% (of 112 countries) in 2021.
- The percentage of countries that have limited or suspended mobile clinic care has decreased from 61% (of 129 countries) in 2020 to 45% (of 112 countries) in 2021.
- The percentage of countries that have limited or suspended inpatient services has decreased from 52% (of 129 countries) in 2020 to 36% (of 112 countries) in 2021.

By contrast:

- The percentage of countries that have limited or suspended pre-hospital emergency care services has increased slightly from 13% (of 129 countries) in 2020 to 16% (of 112 countries) in 2021.
- The percentage of countries that have limited or suspended emergency unit services has increased from 8% (of 129 countries) in 2020 to 16% (of 112 countries) in 2021.

Figure 57 demonstrates similar trends in the subset of 75 countries that participated in both survey rounds:

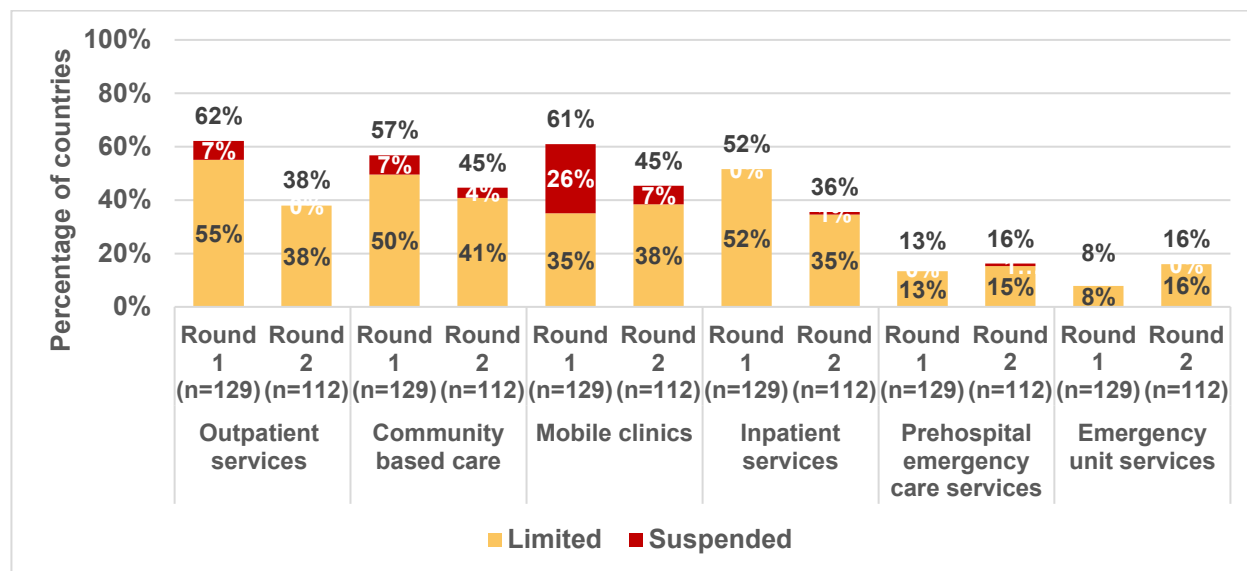
- The percentage of countries that have limited or suspended outpatient services has decreased from 59% (of 75 countries) in 2020 to 41% (of 75 countries) in 2021.
- The percentage of countries that have limited or suspended community-based care has decreased from 57% (of 75 countries) in 2020 to 44% (of 75 countries) in 2021.
- The percentage of countries that have limited or suspended mobile clinic care has decreased from 66% (of 75 countries) in 2020 to 48% (of 75 countries) in 2021.
- The percentage of countries that have limited or suspended inpatient services has decreased from 45% (of 75 countries) in 2020 to 35% (of 75 countries) in 2021.

At the same time, slightly more countries are reporting limited access to emergency care platforms:

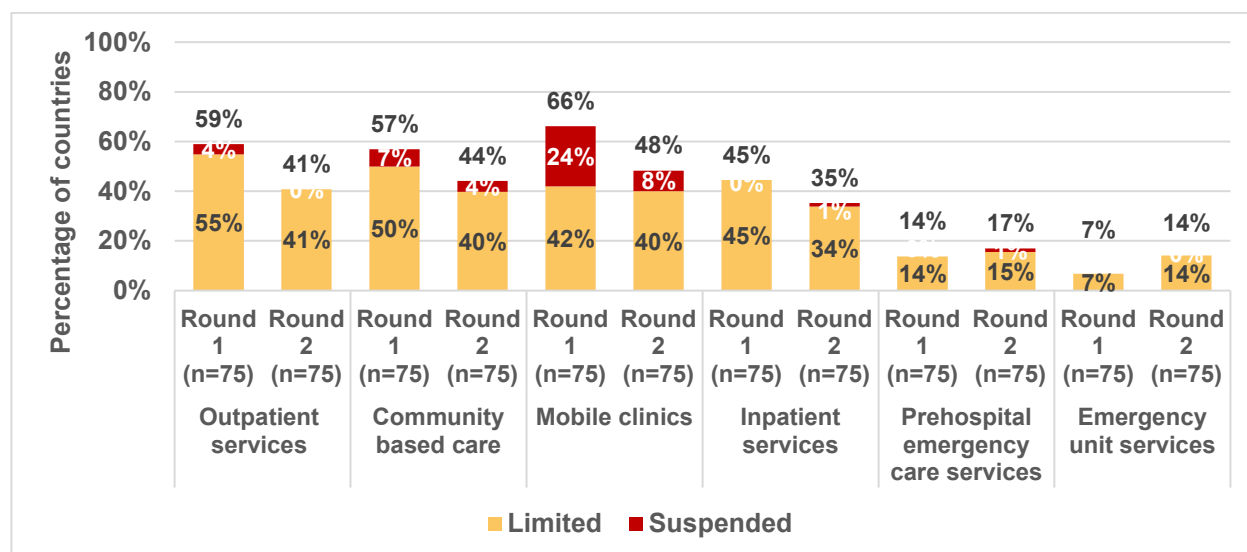
- The percentage of countries that have limited or suspended pre-hospital emergency care services has increased slightly from 14% (of 75 countries) in 2020 to 17% (of 75 countries) in 2021.
- The percentage of countries that have limited or suspended emergency unit services has increased from 7% (of 75 countries) in 2020 to 14% (of 75 countries) in 2021.

Despite the decreases in scaling back access to outpatient, community-based, mobile, and inpatient care, more than one third of countries are still limiting or suspending these service delivery platforms.

**Figure 56: Round 1 vs. Round 2 comparison of countries participating in either survey round:
Government-directed changes affecting the level of access to service delivery platforms**



**Figure 57: Round 1 vs. Round 2 comparison of countries participating in both survey rounds:
Government-directed changes affecting the level of access to service delivery platforms**

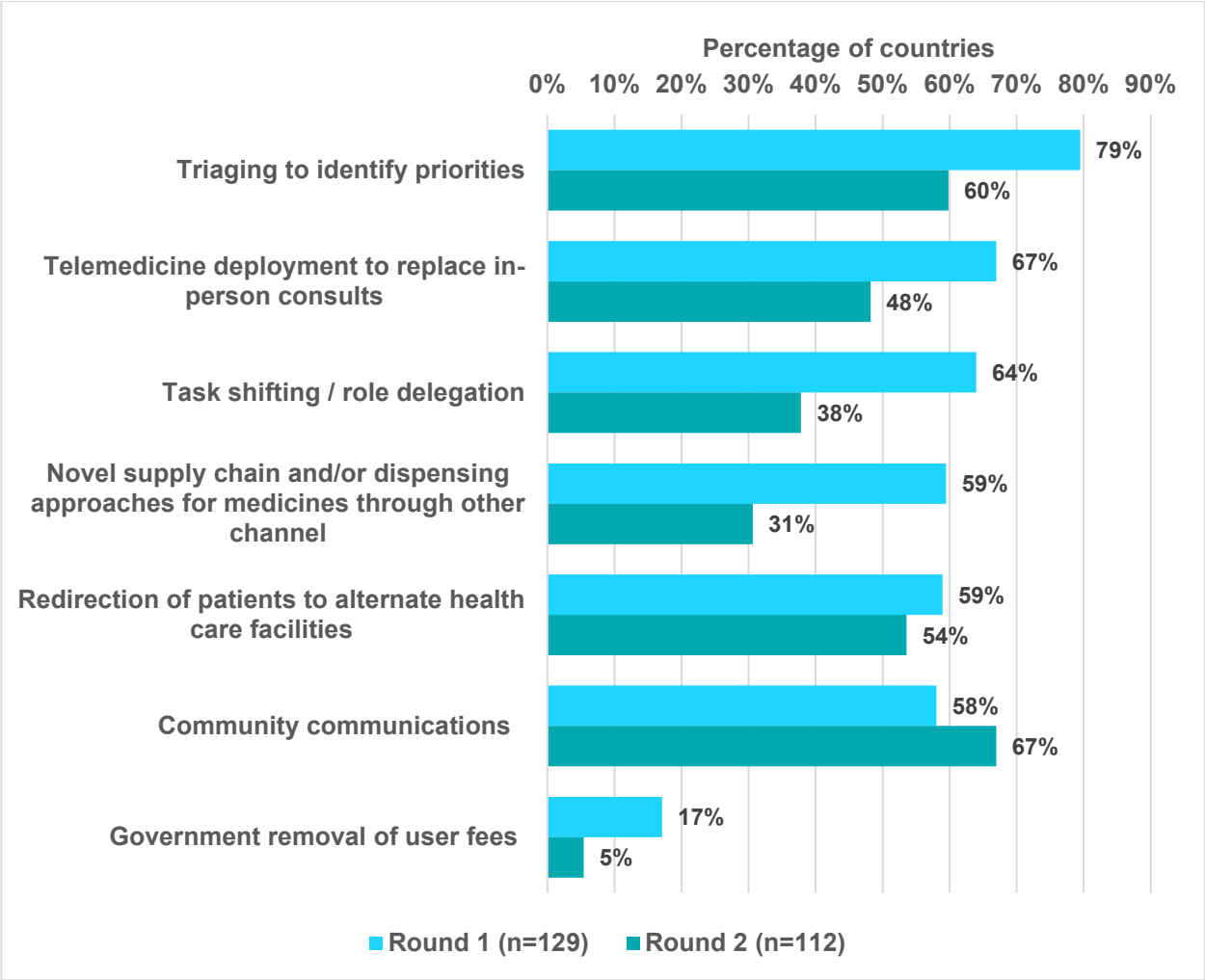


In tracking changes in the percentage of countries reporting use of strategies and approaches for mitigating service disruptions, both types of analyses show a substantial jump in countries' use of communications to address disruptions, such as to inform communities on changes in service delivery or care-seeking advice, to address misinformation or respond to community fear and mistrust.

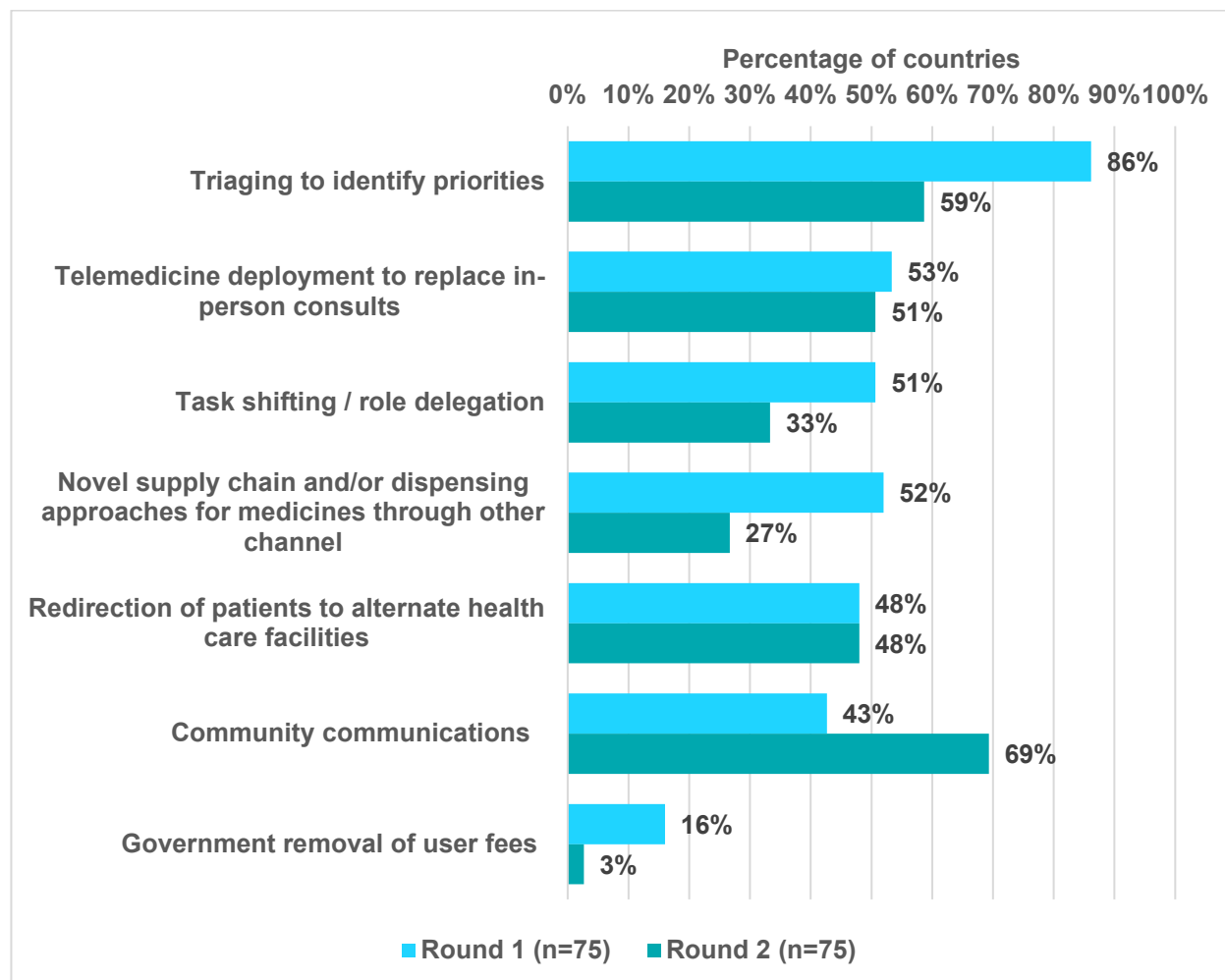
Figure 58 demonstrates that in countries participating in either survey round, 9% more countries are reporting use of intensified community communications.

In the subset of 75 countries that participated in both survey rounds, an even bigger jump is seen; compared to 2020, 20 (26%) more countries are reporting use of community communications (see Figure 59, below).

Figure 58: Round 1 vs. Round 2 comparison of countries participating in either survey round: Approaches for overcoming service disruptions



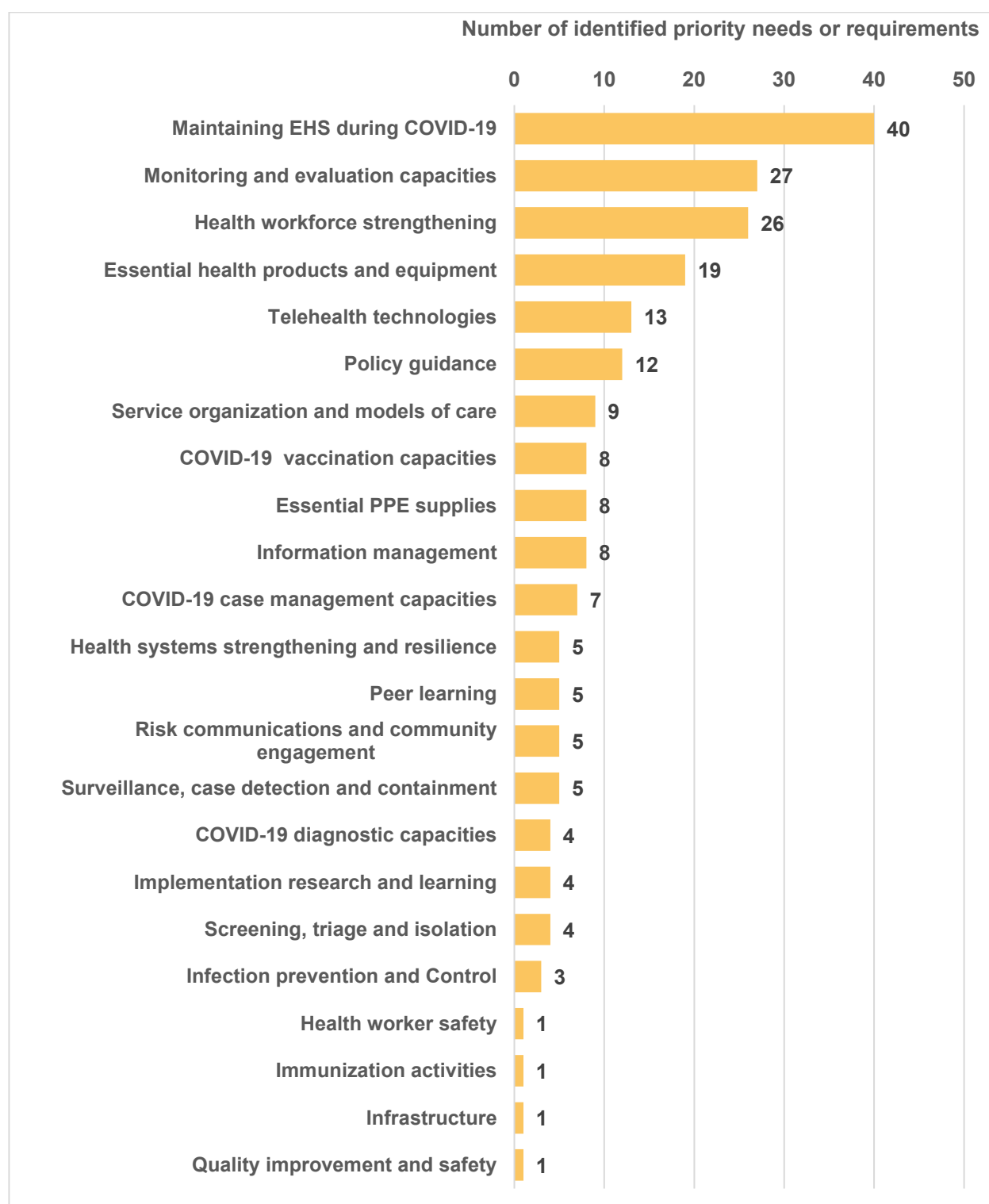
**Figure 59: Round 1 vs. Round 2 comparison of countries participating in both survey rounds:
Approaches for overcoming service disruptions**



Country priorities and technical assistance needs

In response to an open-ended question on priority needs and technical assistance requirements from WHO, 78 countries indicated that they had such needs (see Figure 60, below). These most frequently related to guidance and support for strategies to maintain essential health services, strengthening monitoring and evaluation capacities, strengthening health workforce capacities, assuring access to essential health products and equipment, implementation of telehealth technologies to support service delivery, and policy guidance.

Figure 60: Country priority needs and technical assistance requirements (216 requests from 78 countries)



Conclusions

The *National pulse survey on the continuity of essential health services during the COVID-19 pandemic* provides valuable initial insights from country key informants into the extent of disruptions to health systems and services, the reasons for those disruptions and country experiences in adapting service delivery to maintain or restore essential health services.

The findings show that one year into the pandemic, health systems around the world are still being challenged. Nearly every responding country reported disruptions to one or more essential health service, and disruptions were reported across all service delivery platforms and health areas. This demonstrates the impact of the pandemic across the entire health system and has potential implications on the availability of and access to high-quality services for all, including the most vulnerable, particularly over the long-term, as the indirect consequences of the pandemic persist.

Nonetheless, compared to the key informant responses received during 2020, the findings of the 2021 survey suggest that the magnitude and extent of disruptions within countries is decreasing. These gains and the partial rebound of health systems may be linked to intensified country efforts over the past year to respond to health systems challenges, bottlenecks and barriers to care in the context of COVID-19.

Despite the limitations of this key informant survey for quantifying the extent of disruptions to services, it is reasonable to expect that even moderate interruptions to health service delivery and utilization can lead to worsened health outcomes. The results also shed light on the importance of responsive health policy planning and action, as countries must continue to orient health strategies according to the current and rapidly changing priorities and needs of populations to ensure continued provision of and access to care. The findings also highlight the need to ensure that COVID-19 control strategies are in balance with other health priorities, such as ensuring that adequate staff are available and infection prevention and control measures are in place to protect health worker and patient safety throughout the delivery of both COVID-19 and other essential care.

Further information, including from subnational, health facility and community levels should be used to supplement these findings and better quantify the potential impact of disruptions over the short, medium and long term. Moreover, further documentation and learning on which mitigation strategies and approaches work best for restoring services and in what settings, as well as the benefits and risks of pursuing different strategies throughout the pandemic, are needed to inform actions towards recovery.

In the context of the COVID-19 pandemic, WHO's mission is to continue to support countries as they respond to the increased strains being placed on health systems while ensuring continued access to care to close the remaining gaps in service delivery and ensure that the comprehensive health needs of all are met.

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Annex 1: National pulse survey on continuity of essential health services during the COVID-19 pandemic

Purpose

The *National pulse survey on continuity of essential health services during the COVID-19 pandemic* aims to rapidly assess the extent of impact of the COVID-19 pandemic on health systems and essential health services throughout the course of the pandemic. This survey provides immediate insight from country key informants into the current country experience and extent of disruptions across the entire health system against a rapidly changing context.

Use

By providing a rapid snapshot of the situation, this survey supports decision-makers to systematically take stock of current challenges in service delivery and utilization in the absence of other real-time quantitative data to inform priority needs and resource investments as the pandemic progresses through its various stages. Countries should use the findings to document early learning and guide policy dialogues on what actions need to be taken to maintain the delivery of high-quality essential health services while responding to the pandemic.

Key informants and content areas

The pulse survey consists of questions related to current national policies, plans and structures, disruptions to health services, reasons for disruptions, mitigation approaches, information tracking, and priority needs. It includes sections that target different key informants in the country, including a section on cross-cutting health system functions and services, and focused sections on disruptions to service-specific areas.

The online survey has been designed so that each section can be answered simultaneously by respective country focal points to facilitate rapid completion, reduce burden on individual respondents, and ensure that each content area is assessed by its respective technical focal point. Survey sections and suggested key informants are included in the table below.

#	Survey section	Suggested key informant(s)
1.	Health system functions and cross-cutting services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care	Health system, service delivery, or essential health services focal point(s)
2.	Reproductive, maternal, newborn, child and adolescent health and nutrition	Reproductive, maternal, newborn, child and adolescent health, and nutrition focal point(s)
3.	Immunization	Immunization focal point(s)
4.	Human immunodeficiency virus and hepatitis	Human immunodeficiency virus and hepatitis focal point(s)
5.	Tuberculosis	Tuberculosis focal point(s)
6.	Malaria	Malaria focal point(s)
7.	Neglected tropical diseases	Neglected tropical diseases focal point(s)
8.	Noncommunicable diseases	Noncommunicable diseases focal point(s)
9.	Mental, neurological and substance use disorders	Mental health and psychosocial support focal point(s)

A survey focal point (from WHO CO and/or within the Ministry of health as appropriate to country context) should lead the survey coordination process, including:

1. Identifying national focal points/key informants to complete each survey section;
2. Disseminating the survey link to relevant national focal points/key informants; and
3. Tracking and following up completion of survey sections.

Ideally, survey key informants can come together to discuss and align responses across the sections prior to submission. If this is not possible given the current constraints and limitations due to the pandemic, each survey section can be completed independently by its respective key informant.

In either case, it is essential that the Ministry of Health organize a meeting with key informants, focal points and other key stakeholders to jointly review the results, discuss the implications of disruptions across the health system, flag critical challenges and bottlenecks, and identify the most effective mitigation strategies and approaches for maintaining essential health services while responding to the COVID-19 pandemic. Where available, further data (such as from health facilities) should be triangulated and contribute to the dialogue.

Large decentralized countries may consider completion of the pulse survey at the subnational level to gain rapid insight into the situation and range of challenges and bottlenecks across the country, to then be aggregated at the national level. If this may be of interest, please contact EHSmonitoring@who.int for survey support.

Reporting period

The questions refer to the 3-month time period preceding the month of survey completion. In the case of survey completion in December, this refers to: September, October and November 2020. In the case of survey completion in January, this refers to: October, November, December 2020.

How to complete the survey

Please click on the survey section links to review the WHO data sharing agreement (annex 1) and access the survey sections. Key informants may access the survey sections as many times as needed, saving responses along the way. Please note that multiple users cannot access the same section at the same time. A single key informant should be designated to complete each survey section; this will reduce the risk of overwriting other's responses should multiple key informants enter a survey section. Once each section is submitted, the answers may be printed for record.

Please note that all personal and identifying details will be kept confidential and not included in reporting. These details will only be used to follow up in the case of any clarifications regarding the survey responses.

Health system functions and cross-cutting services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care

This section will assess cross-cutting health system areas, including: national policies and plans; disruptions to services for health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care; reasons for service disruptions; mitigation strategies and approaches; and information tracking.

Respondent information

Who is the focal point(s) who provided the responses?

Name: _____

Position: _____

Organization: _____

Country: _____

Email Address: _____

#	Questions	Response options	
	Policies and plans		
1.	Has your country defined a national essential health services package prior to the COVID-19 pandemic?	1. Yes 2. No 3. Do not know If you did not already in the previous pulse survey, please upload or link your country's national plan or document in which the national essential health services package is defined.	
2.1	Has your country identified a core set of essential health services to be maintained during the COVID-19 pandemic?	1. Yes 2. No/ Not Yet 3. Do not know	
2.2	If yes to 2.1, have policies and plans regarding maintenance of essential health services been revised in the previous 3 months?	1. Yes 2. No 3. Do not know If you did not already in the previous pulse survey, please upload or link your country's most recent national COVID-19 preparedness and response plan and/or document containing guidance for maintenance of essential health services during the COVID-19 pandemic.	
3.	Is there a national focal point or coordinator for maintaining essential health services during the COVID-19 pandemic as part of the national incident/emergency management structure?	1. Yes 2. No 3. Do not know	
4.	During the previous 3 months, has the government allocated additional funding for maintaining essential health services?	1. Yes 2. No 3. Do not know	
5.	During the previous 3 months, how have government policies and directives affected the level of access	Outpatient services Inpatient services	☐ Functioning as normal ☐ Limited access ☐ Suspended

	to the following service delivery platforms?:	Emergency unit services Prehospital emergency care services (e.g. ambulance transport) Community-based care (e.g. outreach campaigns, home-based care, care in long-term facilities³) Mobile clinics	☐ Do not know
6.	During the previous 3 months, how have government policies and directives affected the following essential public health functions?:	Health protection (e.g. management of environmental, food, toxicological and occupational safety) Health promotion population-based activities Disease prevention population-based activities Surveillance and response Emergency preparedness and response Communications and social mobilization activities for health Public health research	☐ Functioning as normal ☐ Limited ☐ Suspended ☐ Do not know

Service disruptions

7.1	During the previous 3 months, which of the following primary care services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual	Services Health promotion and prevention services (e.g. counselling, risk factor assessment, etc.) Routine scheduled visits with primary care providers	What was the level of disruption (percentage of users not served as usual)? ☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)? ☐ Yes ☐ No ☐ Do not know
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³ Long-term care facility: Long-term care facilities may vary by country. Nursing homes, skilled nursing facilities, assisted living facilities, residential facilities and residential long-term care facilities are collectively known as long-term care facilities that provide a variety of services, including medical and assistive care, to people who are unable to live independently in the community. WHO, Preventing and managing COVID-19 across long-term care services: policy brief. Geneva: World Health Organization; 2020. (<https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy-Brief-Long-term-Care-2020.1>)

	Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Visits for undifferentiated symptoms (e.g. chronic fatigue, lower back pain, headache) Prescription renewals for chronic medications Emergency referrals for time-sensitive conditions Referrals to specialty care		
7.2	During the previous 3 months, which of the following emergency care services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Ambulance services at the scene (not including ambulance transport between facilities) Acuity-based triage in emergency units 24-hour emergency room/unit services (e.g. myocardial infarction, stroke, shock, asthma, pneumonia, sepsis and serious injury) Urgent blood transfusion services	☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	☐ Yes ☐ No ☐ Do not know
7.3	During the previous 3 months, which of the following additional services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Outbreak detection and control (for non-COVID diseases) Elective surgeries Emergency surgeries (excluding obstetric) Emergency obstetric surgeries Inpatient critical care services (e.g. respiratory support, haemodynamic support) Rehabilitation services Palliative services Long-term care services (e.g. assistive care for older people who are care dependent/caregiving services)	☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	☐ Yes ☐ No ☐ Do not know
7.4	During the previous 3 months, which of the following auxiliary services have been disrupted due to COVID-19?	Laboratory services Radiology services	☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5%	☐ Yes ☐ No ☐ Do not know

	For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country		☐ Do not know ☐ Not applicable	
8.	During the previous 3 months, what has been the trend in the case volume of your national surgical backlog?	1. Decreased 2. Increased 3. Do not know		
9.	During the previous 3 months, have there been disruptions to the in-country supply chain systems?	1. Yes 2. No 3. Do not know		
Reasons for service disruptions				
10.	During the previous 3 months, what have been the main reasons for service disruption(s) and/or change(s) in service utilization? (check all that apply)	Supply-side factors 1. Closure of outpatient services as per government directive 2. Closure of outpatient disease specific consultation clinics 3. Closure of population level screening programmes 4. Decrease in inpatient volume due to cancellation of elective care 5. Inpatient services/hospital beds not available 6. Insufficient staff to provide services 7. Related clinical staff deployed to provide COVID-19 relief 8. Insufficient Personal Protective Equipment (PPE) available for health care providers to provide services 9. Unavailability/Stock out of essential medicines, medical diagnostics or other health products at health facilities 10. Changes in treatment policies for care seeking behaviour (e.g. stay at home policies) 11. Others (please specify what are the other causes of this disruption and/or changes in service utilization): 12. Do not know Demand-side factors 1. Decrease in outpatient volume due to patients not presenting 2. Community fear/mistrust in seeking health care 3. Travel restrictions hindering access to the health facilities 4. Financial difficulties during outbreak/lock down 5. Others (please specify what are the other causes of this disruption and/or changes in service utilization): 6. Do not know		
Mitigation strategies				
11.	During the previous 3 months, what approaches have been used to overcome service disruptions to essential health services in public	1. Triage to identify priorities 2. Redirection of patients to alternate care sites /reorientation of referral pathways 3. Telemedicine deployment to replace in-person consults 4. Integration of several services into single visit		

	sector health facilities and long-term care facilities? (check all that apply)	5. Self-care interventions where appropriate 6. Provision of home-based care where appropriate 7. Catch-up campaigns for missed appointments 8. Task shifting / role delegation 9. Recruitment of additional staff 10. Expanding facility hours 11. Novel supply chain management and logistics approaches 12. Novel dispensing approaches for medicines 13. Novel prescribing approaches (e.g. tele-prescription, extended drug prescriptions) 14. Community communications (e.g. informing on changes to service delivery, addressing misinformation and community fears of infection) 15. Government removal of user fees 16. Others (please describe what other approaches are being used): 17. Do not know
12.	During the previous 3 months, what approaches have been used to ensure access to care for vulnerable groups?	1. Identifying vulnerable groups of primary concern 2. Use of proactive governmental strategies to reach out to vulnerable groups 3. Use of existing networks or organizations (e.g. NGOs) to reach out to vulnerable groups 4. Other (please specify) 5. Do not know
13.	During the previous 3 months, for which of the following services have telehealth technologies been used?: (check all that apply)	1. Pharmacy and medication refills 2. Scheduling appointments 3. Imaging diagnostics 4. Emergency care consultations 5. Primary care consultations 6. Family planning counselling 7. Prenatal care consultations 8. Child health consultations 9. Mental health consultations 10. Chronic care consultations 11. Eye care consultations 12. Other (please specify): 13. None 14. Do not know
14.	During the previous three months, to what degree has your country used eLearning or digital learning for training or supervision of health workforce? eLearning or digital learning refers to the use of ICT and digital technologies for training and education.	1. Not used at all 2. No change in use 3. Expanded use 4. Do not know
15.	What barriers have prevented use of telehealth technologies? (check all that apply)	1. Lack of funding to set up and implement programmes 2. Limited organizational or technical capacities to transition to use 3. Limited awareness/knowledge of patients and/or providers regarding telehealth technologies 4. Limited access to telehealth technologies for patients and/or providers (e.g. telephone or videoconferencing) 5. Security and privacy concerns 6. Legal or regulatory barriers (e.g. reimbursement) 7. Other (please specify): 8. Do not know

16.	What are your country's plans to re-initiate any limited or suspended services? Please upload or link to national document if available.	
Information tracking		
17.1	Is your country regularly monitoring the continuity of essential health services during the COVID-19 pandemic?	1. Yes 2. No 3. Do not know
17.2	If yes to 17.1, does this include regular monitoring the implementation of approaches and mitigation strategies to overcome service disruptions?	1. Yes 2. No 3. Do not know
18.	Does your country currently have a team dedicated to tracking and addressing the infodemic and health misinformation? (e.g. a taskforce or unit for: analysing and monitoring misinformation online and offline, and how it affects acceptance of public health measures and health seeking behaviours; analysing and proposing evidence-based interventions to counter misinformation at national, subnational, community and individual levels)	1. Yes, within Ministry of Health or equivalent 2. Yes, within government but in another ministry 3. Not yet, but planning on setting up a unit 4. No unit, but we have staff completing these tasks 5. No 6. Do not know If yes, when was the unit set up? (DD/MM/YYYY) If yes, who is the contact person for the infodemic and health misinformation response? (open text)
19.	Is your country collecting or collating data on comorbidities in COVID-19 patients?	1. Yes 2. No 3. Do not know 4. Not applicable
Priorities and technical assistance needs		
20.	What are your most urgent priority needs and technical assistance requirements from WHO for maintaining essential health services during the COVID-19 pandemic?	Please use the text box to give your suggestions

Please add any comments on the questions above.

Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int

Reproductive, maternal, newborn, child and adolescent health and nutrition

This section will assess disruptions to services for reproductive, maternal, newborn, child and adolescent health and nutrition.

Respondent information

Who is the focal point who provided the responses?

Name: _____

Position: _____

Organization: _____

Country: _____

Email Address: _____

#	Questions	Response options		
	Service disruptions			
1.	During the previous 3 months, which of the following services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Services Family planning and contraception Antenatal care Facility-based births Postnatal care for women and newborns Safe abortion and post-abortion care Sick child services Management of moderate and severe malnutrition Intimate partner and sexual violence prevention and response	What was the level of disruption (percentage of users not served as usual)? ☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Not disrupted ☐ Do not know ☐ Not applicable	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)? ☐ Yes ☐ No ☐ Do not know

Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int

Immunization

This section will assess disruptions in supply and demand to immunization services.

Respondent information

Who is the focal point who provided the responses?

Name: _____

Position:

Organization: _____

Country:

Email Address:

#	Questions	Response options		
	Service disruptions			
1.	During the previous 3 months, which of the following services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Services	What was the level of disruption (percentage of users not served as usual)?	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)?
		Routine facility-based immunization services Routine outreach immunization services	☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	☐ Yes ☐ No ☐ Do not know
2.	Please complete the following statement: Compared to March-August, routine immunization services for September-November have been: (disruptions can be due to service provision or reduced demand of immunization services or both):	☐ Less disrupted than between March-August 2020, but not yet back to pre-pandemic levels ☐ Less disrupted than between March-August 2020, and reached pre-pandemic levels ☐ Less disrupted than between March-August 2020, and reached higher levels than pre-pandemic ☐ More disrupted than in March-August 2020 ☐ Do not know ☐ Other _____		
3.	Please indicate the level of disruption that occurred to demand for immunization services as a result of COVID-19 and associated epidemic prevention measures (e.g. travel restrictions, limitations in people being in groups, etc.) between the months of September-November 2020:	☐ No disruptions: demand for vaccination continues as before the pandemic ☐ Disruptions to demand for vaccination, but less disruptions than in between March-August 2020 ☐ Disruptions to demand for vaccination, and more disruptions than in between March-August 2020 ☐ Disruptions to demand for vaccination are similar to those seen between March-August 2020 ☐ Do not know about disruptions to demand for vaccination		

Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int

Human immunodeficiency virus and hepatitis

This section will assess disruptions to human immunodeficiency virus (HIV) and hepatitis services.

Respondent information

Who is the focal point who provided the responses?

Name: _____

Position: _____

Organization: _____

Country: _____

Email Address: _____

#	Questions	Response options		
	Service disruptions			
1.	During the previous 3 months, which of the following services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Services Human immunodeficiency virus (HIV) prevention services (e.g. pre-exposure prophylaxis, provision of condoms and lubricants, voluntary medical male circumcision, harm reduction services) Human immunodeficiency virus (HIV) testing services Continuation of established antiretroviral (ARV) treatment Initiation of new antiretroviral (ARV) treatment Hepatitis B and C diagnosis and treatment	What was the level of disruption (percentage of users not served as usual)? ☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)? ☐ Yes ☐ No ☐ Do not know

Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int

Tuberculosis

This section will assess disruptions to tuberculosis (TB) services.

Respondent information

Who is the focal point who provided the responses?

Name: _____

Position: _____

Organization: _____

Country: _____

Email Address: _____

#	Questions	Response options		
	Service disruptions			
2.	During the previous 3 months, which of the following services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Services Tuberculosis (TB) diagnosis and treatment	What was the level of disruption (percentage of users not served as usual)? ☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)? ☐ Yes ☐ No ☐ Do not know

Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int

Malaria

This section will assess disruptions to malaria services.

Respondent information

Who is the focal point who provided the responses?

Name: _____

Position: _____

Organization: _____

Country: _____

Email Address: _____

#	Questions	Response options		
	Service disruptions			
3.	During the previous 3 months, which of the following services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Services Malaria diagnosis and treatment Malaria prevention campaigns - Insecticide-treated-mosquito nets (ITN) - Indoor residual spraying (IRS) - Seasonal malaria chemoprevention (SMC)	What was the level of disruption (percentage of users not served as usual)? [] More than 50% [] 26-50% [] 5-25% [] Less than 5% [] Do not know [] Not applicable	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)? [] Yes [] No [] Do not know

Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int

Neglected tropical diseases

This section will focus on neglected tropical diseases (NTDs). These include a diverse group of 20 diseases and disease groups that are mostly communicable and primarily found in tropical and subtropical countries: Buruli ulcer, Chagas disease, dengue and chikungunya, dracunculiasis (Guinea-worm disease), echinococcosis, foodborne trematodiasis, human African trypanosomiasis (sleeping sickness), leishmaniasis, leprosy (Hansen's disease), lymphatic filariasis, mycetoma, chromoblastomycosis and other deep mycoses, onchocerciasis (river blindness), rabies, scabies and other ectoparasites, schistosomiasis, soiled-transmitted helminthiasis, snakebite envenoming, taeniasis/cysticercosis, trachoma, and yaws and other endemic treponematoses.

Respondent information

Who is the focal point who provided the responses?

Name: _____

Position: _____

Organization: _____

Country: _____

Email Address: _____

#	Questions	Response options
INFRASTRUCTURE AND ACTIVITIES		
1.	During the previous three months, have Ministry of Health (or equivalent institutes) staff with responsibility for NTDs been reassigned/deployed to help with overall COVID-19 response?	1. YES – All staff supporting COVID-19 efforts full time 2. YES – All staff partially supporting COVID-19 efforts along with routine NTD activities 3. YES – Some staff supporting COVID-19 efforts full time 4. YES – Some staff partially supporting COVID-19 efforts along with routine NTD activities 5. NO 6. Do not know
2.	During the previous three months, how much of the government (or Ministry of Health) funds initially allocated for NTDs have been reassigned to non-NTD services due to COVID-19 response efforts?	1. None or not yet 2. 1 - 25% 3. 26 -50% 4. 51-75% 5. 76 -100% 6. Do not know
3.	During the previous three months, which of the following planned Ministry of Health NTD activities have been postponed because of COVID-19? (check all that apply)	1. Advocacy and resource mobilization for NTD programme 2. Training and capacity-building activities (in-person or virtual) related to NTDs 3. Surveys/population screening/surveillance for active case finding If yes, please specify which NTD: 4. Integrated vector management If yes, please specify which vector control activities (e.g. mollusciciding, pond treatments, indoor residual/space spraying, source reduction measures, environment management) 5. Animal health/control of zoonotic NTDs 6. Monitoring, evaluation and research 7. Information reporting on NTDs 8. None 9. Do not know

SERVICE DISRUPTIONS				
4.	During the previous 3 months, which of the following services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Services Diagnosis, treatment and care for NTDs (facility-based) Large scale preventive chemotherapy campaigns for NTDs (e.g. mass drug administrations, and/or school-based treatments) Community awareness and health education campaigns for NTDs (e.g. WASH promotion, disease prevention, vector control, eradication) Support for self-care, rehabilitation and psychosocial services for patients with chronic NTDs Prescriptions for NTD medicines Surgical procedures for NTDs	What was the level of disruption (percentage of users not served as usual)? ☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)? ☐ Yes ☐ No ☐ Do not know
5.	During the previous three months, what has been the impact of COVID-19 on the following?	1. Mortality related to NTDs 2. Funding for related NTD activities 3. Visibility of population at risks for NTDs 4. Prioritization of NTD activities 5. Expiration of NTD medicines and diagnostics 6. Stock out of NTD medicines and diagnostics 7. Other impact on NTDs activities and/or outcomes (please specify)	☐ Increased ☐ Reduced ☐ No change or effect ☐ Do not know ☐ Not applicable	
6.	What are your country's plans to re-initiate any suspended NTD services?			

WHO GUIDANCE: UPTAKE, INFORMATION SHARING AND UNMET NEEDS

- | | |
|----|---|
| 7. | Are there any technical guidance or tools that you would suggest WHO to develop related to NTDs during COVID-19 outbreak? |
|----|---|

Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int

Please visit https://www.who.int/neglected_diseases/diseases/summary/en/ for more information on NTDs.

Noncommunicable diseases

This section will assess disruptions to noncommunicable disease (NCD) services.

Respondent information

Who is the focal point who provided the responses?

Name: _____

Position: _____

Organization: _____

Country: _____

Email Address: _____

Q#	Questions	Response options
INFRASTRUCTURE		
1.	During the previous 3 months, have the Ministry of Health (or equivalent institutes) staff with responsibility for NCDs and their risk factors been reassigned/deployed to help with overall COVID-19 response?	1. YES – All staff supporting COVID-19 efforts full time 2. YES – All staff partially supporting COVID-19 efforts along with routine NCD activities 3. YES – Some staff supporting COVID-19 efforts full time 4. YES – Some staff partially supporting COVID-19 efforts along with routine NCD activities 5. NO 6. Do not know
2.	During the previous 3 months, how much of the government (or Ministry of Health) funds initially allocated for NCDs have been reassigned to non-NCD services due to COVID-19 response efforts?	1. None or not yet 2. 1 - 25% 3. 26 -50% 4. 51-75% 5. 76 -100% 6. Do not know
POLICIES AND PLANS		
3.	During the previous 3 months, has additional funding been allocated for NCDs in the government budget for the COVID-19 response?	1. Yes 2. No 3. Do not Know
4.	During the previous 3 months, which of the following Ministry of Health NCD activities planned for this year been postponed because of COVID-19? (check all that apply)	1. None 2. Implementation of NCD Surveys 3. Public screening programmes for NCDS 4. WHO Package for Essential NCDs (PEN) training and implementation in Primary Health Care 5. WHO HEARTS technical package 6. Mass communication campaigns 7. Others (please specify what other NCD activity/activities have been postponed due to COVID-19) 8. Do not know

DISRUPTIONS TO NCD SERVICES

5.	During the previous 3 months, which of the following services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Services Hypertension Management Cardiovascular emergencies (including MI, Stroke and cardiac Arrhythmias) Cancer screening Cancer Treatment Diabetes and Diabetic Complications Management Asthma services Urgent dental care	What was the level of disruption (percentage of users not served as usual)? ☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)? ☐ Yes ☐ No ☐ Do not know
6.	What are your country's plans to re-initiate any suspended NCD services?			

OTHER SUGGESTIONS

7.	Are there any technical guidance or tools that you would suggest WHO to develop related to NCDs during COVID-19 outbreak?	Please use the text box to give your suggestions
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Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int and ncdmonitoring@who.int

Please add any comments on the questions above.

Terms: Reassigned/deployed: Temporarily assigned to another unit or team

Mental, neurological, and substance use disorders

This section will assess disruptions in services for mental, neurological and substance use disorders.

Respondent information

Who is the focal point who provided the responses?

Name: _____

Position: _____

Organization: _____

Country: _____

Email Address: _____

#	Questions	Response options
	Policies and plans	
1.1	Is mental health and psychosocial support response part of national COVID-19 response plan?	a. Yes b. No c. Do not know
1.2	If yes to 1.1, during the previous 3 months, has additional funding been allocated for mental health and psychosocial support in the government budget for the COVID-19 response plan?	a. Yes and 100 % funded b. Yes but only partially funded c. No d. Do not know
1.3	If yes to 1.1, during the previous three months, which of the following activities have been implemented as part of the current mental health and psychosocial support (MHPSS) response plan for COVID-19? (Please check all activities that apply) See further examples for each activity in the complementary glossary - section A.	a. Orient responders to mental health and psychosocial aspects of COVID-19 b. Ensure inter-sectoral referral pathways are established and contextualized to the situation of limited physical distancing c. Distribute timely and accessible information on general and MHPSS services, coping strategies and updates d. Provide MHPSS to people in COVID treatment centres, isolation and quarantine e. Protect the mental health and well-being of all responders ensuring that they can access mental health and psychosocial care. f. Provide care and address the basic needs and mental health care needs of people with existing MNS conditions induced or exacerbated by COVID-19 g. Address the mental health needs of older adults, people with disabilities and other vulnerable persons h. Targeted Risk communication strategies/ campaigns to address social stigma i. Establish opportunities for the bereaved to mourn even from a distance. Integrate response activities into existing services j. Ensure that risk of infection for people with mental health conditions in mental health hospitals are minimized k. Do not know
2.1	Do you currently have a functioning multisectoral mental health and psychosocial coordination platform for COVID-19 response?	a. Yes b. No c. Do not know
2.2	If yes to 2.1, which of the following Ministries and bodies part of the coordination platform? (Please check all boxes that apply)	a. Ministry of Health b. Ministry of Social/Family Affairs c. Ministry of Education

		d. Ministry of Labour e. Ministry of Finance f. Ministry of Foreign Affairs g. United Nations Agencies h. Governmental entity responsible for substance use i. Non-governmental Organizations j. Service users' representatives k. National professional associations/societies l. National disaster management authority m. Do not know		
3	During the previous three months, how have government policies/directives designated access to essential services for mental, neurological and substance use (MNS) disorders at primary, secondary and tertiary care levels? Please answer for different categories of services for mental, neurological and substance use disorders (see complementary glossary – section B). Please provide the response for national level policies as defined below: Services open: Regular access to services Services partially open: e.g. for emergencies only or at limited capacity Services closed: No access to services Do not know: Information not available / to be found N/A: Not applicable as services non-existent	Level Mental health services at mental hospitals Mental health services at general hospitals Neurology/brain health services at health facilities Services for substance use disorders at health facilities Community-based services for MNS disorders	Status ☐ Services are open ☐ Services are partially open ☐ Services are closed ☐ Do not know ☐ Not Applicable	
Service disruptions				
4	During the previous 3 months, which of the following services have been disrupted due to COVID-19? For each service, please indicate the level of disruption (percentage of users not served as usual) and if the disruptions were related to intentional modifications in service delivery. Definitions: More than 50% of users not served as usual 26-50% of users not served as usual 5-25% of users not served as usual Less than 5% of users not served as usual Do not know: Information is not /not yet available Not applicable: Service/intervention is not usually delivered in country	Services Management of emergency MNS manifestations (including status epilepticus, delirium, severe substance withdrawal syndromes) Psychotherapy/counselling/psychosocial interventions for MNS disorders Prescriptions for MNS disorder medicines	What was the level of disruption (percentage of users not served as usual)? ☐ More than 50% ☐ 26-50% ☐ 5-25% ☐ Less than 5% ☐ Do not know ☐ Not applicable	Were disruptions primarily due to intentional service delivery modifications (e.g. temporary suspension or scaling back of services)? ☐ Yes ☐ No ☐ Do not know

		Services for children and adolescents with mental health conditions or disabilities, including developmental disabilities Services for older adults with mental health conditions or disabilities, including dementia Neuroimaging and neurophysiology School mental health programme Suicide prevention programme Overdose prevention and management programmes (e.g. naloxone distribution) Critical harm reduction services (e.g., needle exchange programmes, outreach services)		
5	What are your country's plans towards restoration and safe delivery of any limited or suspended MNS services? See further considerations and recommended modifications for restoration of safe service delivery in the complementary glossary - section C.	(open text)		
Surveillance				
6	Is your country collecting or collating data on mental, neurological and substance use disorders or manifestations in people with COVID-19?	a. Yes b. No c. Do not know		
7	Is there a planned or ongoing study related to impact of COVID-19 on mental health/ brain health/substance use in the country (by government or anyone else, whether stand-alone or as part of a broader survey). Please check all that apply.	a. Yes, on mental health impact b. Yes, on neurological disorders or brain health c. Yes, on substance use impact d. No e. Do not know		

Thank you for taking time to give your input for this survey. If you have any queries or questions regarding this survey, please contact EHSmonitoring@who.int

Data sharing agreement

Please note that all data collected by WHO, excluding emergencies and clinical trials, from member States requires the below statement in all data collection forms.

For more information on the data policy go to: <http://intranet.who.int/homes/spi/datasharing/>

or outside of WHO: <http://www.who.int/publishing/datapolicy/en/>

Statement of policy on data sharing

Data are the basis for all sound public health actions and the benefits of data sharing are widely recognized, including scientific and public health benefits. Whenever possible, WHO wishes to promote the sharing of health data, including but not restricted to surveillance and epidemiological data.

In this connection, and without prejudice to information sharing and publication pursuant to legally binding instruments, by providing data to WHO, the [Ministry of Health] [other responsible governmental entity] of [Country]:

Confirms that all data to be supplied to WHO (including but not limited to the types listed in Annex 3) hereunder have been collected in accordance with applicable national laws, including data protection laws aimed at protecting the confidentiality of identifiable persons;

Agrees that WHO shall be entitled, subject always to measures to ensure the ethical and secure use of the data, and subject always to an appropriate acknowledgement of [Country]:

- to publish the data, stripped of any personal identifiers (such data without personal identifiers being hereinafter referred to as “the Data”) and make the Data available to any interested party on request (to the extent they have not, or not yet, been published by WHO) on terms that allow non-commercial, not-for-profit use of the Data for public health purposes (provided always that publication of the Data shall remain under the control of WHO);
- to use, compile, aggregate, evaluate and analyze the Data and publish and disseminate the results thereof in conjunction with WHO’s work and in accordance with the Organization’s policies and practices.

Except where data sharing and publication is required under legally binding instruments (IHR, *WHO Nomenclature Regulations 1967*, etc.), the [Ministry of Health][other responsible governmental entity] of [Country] may in respect of certain data opt out of (any part of) the above, by notifying WHO thereof in writing at the following address, provided that any such notification shall clearly identify the data in question and clearly indicate the scope of the opt-out (in reference to the above), and provided that specific reasons shall be given for the opt out.

World Health Organization
WHO HQ/IHS/HAS
1211 Geneva 27
Switzerland
EHSmonitoring@who.int

[] I verify that I have read and understood the data sharing agreement

Annex 2: List of 63 tracer services assessed in the second round of the National pulse survey on continuity of essential health services during the COVID-19 pandemic

Across integrated service delivery channels (n=19)

Primary care

- Health promotion and prevention services
- Routine scheduled visits with primary care providers
- Visits for undifferentiated symptoms
- Prescription renewals for chronic medications
- Emergency referrals for time-sensitive conditions
- Referrals to specialty care

Emergency and critical care

- Ambulance services at the scene
- Acuity-based triage in emergency units
- 24-hour emergency room/unit services
- Urgent blood transfusion services
- Inpatient critical care services

Rehabilitative, palliative and long-term care

- Rehabilitation services
- Palliative services
- Long-term care services

Surgical care

- Elective surgeries
- Emergency surgeries (excluding obstetric)
- Emergency obstetric surgeries

Auxiliary services

- Laboratory services
- Radiology services

Across tracer service areas (n=44)

Reproductive, maternal, newborn, child and adolescent health and nutrition

- Family planning and contraception
- Antenatal care
- Facility-based births
- Postnatal care for women and newborns
- Safe abortion and post-abortion care
- Sick child services
- Management of moderate and severe malnutrition
- Intimate partner and sexual violence prevention and response

Immunization

- Routine facility-based immunization services
- Routine outreach immunization services

Communicable diseases

- Outbreak detection and control
- HIV prevention services
- HIV testing services
- Continuation of established antiretroviral (ARV) treatment
- Initiation of new antiretroviral (ARV) treatment
- Hepatitis B and C diagnosis and treatment
- TB diagnosis and treatment
- Malaria diagnosis and treatment
- Insecticide-treated-mosquito nets (ITN) campaigns
- Indoor residual spraying (IRS) campaigns
- Seasonal malaria chemoprevention (SMC) campaigns

Neglected tropical diseases (NTDs)

- Diagnosis, treatment and care for NTDs (facility-based)
- Large scale preventive chemotherapy campaigns for NTDs
- Community awareness and health education campaigns for NTDs
- Support for self-care, rehabilitation and psychosocial services for patients with chronic NTDs
- Prescriptions for NTD medicines
- Surgical procedures for NTDs

Noncommunicable diseases

- Hypertension Management
- Cardiovascular emergencies
- Cancer screening
- Cancer Treatment
- Diabetes and Diabetic Complications Management
- Asthma services
- Urgent dental care

Mental, neurological, and substance use (MNS) disorders

- Management of emergency MNS manifestations
- Psychotherapy/counseling/psychosocial interventions for MNS disorders
- Prescriptions for MNS disorder medicines
- Services for children and adolescents with mental health conditions or disabilities, including developmental disabilities
- Services for older adults with mental health conditions or disabilities, including dementia
- Neuroimaging and neurophysiology
- School mental health programmes
- Suicide prevention programmes
- Overdose prevention and management programmes
- Critical harm reduction services

Annex 3: List of countries, territories and areas that participated in the second round of the pulse survey on continuity of essential health services during the COVID-19 pandemic

WHO would like to express its gratitude to all authorities and WHO Country Offices that supported participation in the second round of this survey.

African region

- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cabo Verde
- Cameroon
- Central African Republic
- Chad
- Comoros
- Congo (Republic of the)
- Côte d'Ivoire
- Democratic Republic of the Congo
- Eritrea
- Eswatini
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mauritania
- Mauritius
- Mozambique
- Namibia
- Niger
- Rwanda
- Sao Tome and Principe
- Senegal
- Seychelles
- South Africa
- South Sudan
- Togo
- Uganda
- Zambia

Region of the Americas

- Argentina
- Bahamas
- Belize
- Bermuda
- Bolivia (Plurinational State of)
- Brazil

- British Virgin Islands (United Kingdom of Great Britain and Northern Ireland)
- Cayman Islands
- Chile
- Costa Rica
- Cuba
- Dominica
- Dominican Republic
- Ecuador
- El Salvador
- Grenada
- Guatemala
- Haiti
- Honduras
- Jamaica
- Mexico
- Nicaragua
- Panama
- Paraguay
- Peru
- Saint Lucia
- Saint Vincent and the Grenadines
- Suriname
- Uruguay

Eastern Mediterranean region

- Afghanistan
- Bahrain
- Djibouti
- Egypt
- Iran (Islamic Republic of)
- Iraq
- Jordan
- Kuwait
- Lebanon
- Morocco
- occupied Palestinian territory, including east Jerusalem
- Oman
- Pakistan
- Qatar
- Saudi Arabia
- Somalia
- Sudan
- Syrian Arab Republic
- Tunisia
- United Arab Emirates
- Yemen

European region

- Albania
- Armenia
- Austria
- Bulgaria
- Croatia
- Czechia
- Denmark
- Estonia
- Finland
- France

- Georgia
- Hungary
- Italy
- Kazakhstan
- Latvia
- Portugal
- Republic of Moldova
- Sweden
- Turkmenistan
- Ukraine
- United Kingdom of Great Britain and Northern Ireland

South-East Asian region

- Bangladesh
- Bhutan
- Democratic People's Republic of Korea
- Indonesia
- Maldives
- Nepal
- Sri Lanka
- Thailand
- Timor-Leste

Western Pacific region

- Australia
- Brunei Darussalam
- China
- Fiji
- French Polynesia (France)
- Japan
- Lao People's Democratic Republic
- Malaysia
- Papua New Guinea
- Philippines
- Republic of Korea
- Solomon Islands
- Vanuatu

